

6178

# CERTIFICATE OF DEATH

06170

Reg. Dist. No. 302

302

1. PLACE OF DEATH a. COUNTY <b>Washington</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>5 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>		d. STREET ADDRESS <b>Maryland Hotel</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Wash. County Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>FORREST</b>		First <b>CARMILLES</b>		Middle <b>ALLOMONG Sr</b>		Last <b>May</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jany 25 1887</b>	
9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Real Estate Broker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>		11. BIRTHPLACE (State or foreign country) <b>W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph K. Allemong</b>		14. MOTHER'S MAIDEN NAME <b>Virginia Welch</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-16-3343</b>		17. INFORMANT <b>Gladstone L. Allemong</b>		Address <b>250 No Mulberry St</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 Ventricular Fibrillation</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Thrombosis</b> DUE TO (c) <b>5 days</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 12, 1958</b> to <b>May 18, 1958</b> , that I last saw the deceased alive on <b>May 18, 1958</b> , and that death occurred at <b>4:30 P.M.</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>318 N. Patowmac St Hagerstown, Md</b>		DATE SIGNED <b>5-19-58</b>			
ACTUAL SIGNATURE <b>Paul Harrison MD</b>		M.D. <b>Patowmac St Hagerstown, Md</b>					
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/21/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Wash. Co Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>		ADDRESS <b>Hagerstown Md.</b>		24a. REC'D BY REGISTRAR <b>MAY 23 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Quincy</b>	

**TO HOSPITAL OR A PROVIDING PHYSICIAN:** The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6179 CERTIFICATE OF DEATH

Reg. Dist. No.

06171

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown, Md.</b>				c. LENGTH OF STAY IN 1b <b>60yrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>421E Summans Ave</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Anna</b> Middle <b>Elizabeth</b> Last <b>Barnes</b>				4. DATE OF DEATH Month <b>May</b> Day <b>16</b> Year <b>1958</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Celored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept 8 1879</b>	
9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>Keedysville, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>							
13. FATHER'S NAME <b>George Clark</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Wright</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Minnie Barnes 421E Summans Ave.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary artery disease</b> DUE TO (c) <b>Hypertensive cardiovascular disease</b> INTERVAL BETWEEN ONSET AND DEATH <b>hours</b> <b>years</b> <b>years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>260X Diabetes mellitus</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>no injury</b>							
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 2</b> 19 <b>58</b> to <b>May 16</b> 19 <b>58</b> that I last saw the deceased alive on <b>May 4</b> 19 <b>58</b> , and that death occurred at <b>12:15M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>145 South Prospect St.</b> DATE SIGNED							
ACTUAL SIGNATURE <b>John C. Stauffer</b>				M.D. <b>145 South Prospect St.</b>			
PHYSICIAN'S NAME (Type) <b>John C. Stauffer</b>				<b>Hagerstown, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-19-1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John R Watson Jr</b>				ADDRESS <b>Hagerstown Md</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 23 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Alfred Smith</b>			



212

10. *gustatus* (L.) *gustatus* (L.)



68229

## CERTIFICATE OF DEATH

Reg. Dist. No. 06172

1. PLACE OF DEATH o. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL WILSONS				c. LENGTH OF STAY IN 1b 60 YEARS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WILLIAMSPORT RT 2				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X RURAL WILSONS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WILLIAMSPORT RT 2				d. STREET ADDRESS / WILLIAMSPORT RT 2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARY ELIZABETH BLOYER				4. DATE OF DEATH		Month 5 Day I Year 1958	
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 15, 1893	
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) PENNA.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME JOSEPH HOFFMAN				14. MOTHER'S MAIDEN NAME ALICE MYERS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. NONE		17. INFORMANT CHARLES F. BLOYER SR. Address WILLIAMSPORT	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary artery occlusion with myocardial infarction DUE TO (b) Arteriosclerotic Hypertensive Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from April 27, 1958, to May 1, 1958, that I last saw the deceased alive on April 30, 1958, and that death occurred at 5:30 am from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Archie Robert Cohen M.D.							
PHYSICIAN'S NAME (Type) Archie Robert Cohen, M.D. Clear Spring, Maryland May 1, 1958							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5/3/58		22c. NAME OF CEMETERY OR CREMATORY ST. PAULS		22d. LOCATION (City, town, or county) (State) WASHINGTON CO. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE John F. Clark ADDRESS CLEAR SPRING, MD.				24a. REC'D BY REGISTRAR MAY 5 '58		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES J. JONES		45		M		W		1880		NEW YORK	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		MEDICAL OPINION	
JAN 10 1918		NEW YORK		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE		NO	
TIME OF DEATH		HOURS		MINUTES		P.M.		TEMPERATURE		PULSE	
10:00		10		00		P		98.6		60	
DATE OF INTERMENT		PLACE OF INTERMENT		NAME OF INTERMENT		CITY		STATE		COUNTRY	
JAN 12 1918		NEW YORK		ST. JOHN'S		NEW YORK		NEW YORK		UNITED STATES	
NAME OF PHYSICIAN		NAME OF SURGEON		NAME OF NURSE		NAME OF MIDWIFE		NAME OF DENTIST		NAME OF OTHER	
J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES	
SIGNATURE OF PHYSICIAN		SIGNATURE OF SURGEON		SIGNATURE OF NURSE		SIGNATURE OF MIDWIFE		SIGNATURE OF DENTIST		SIGNATURE OF OTHER	
J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES	
DATE OF SIGNATURE		PLACE OF SIGNATURE		NAME OF SIGNATURE		CITY		STATE		COUNTRY	
JAN 10 1918		NEW YORK		J. J. JONES		NEW YORK		NEW YORK		UNITED STATES	

MASSACHUSETTS STATE DEPARTMENT OF HEALTH-BALTIMORE 18



6180 CERTIFICATE OF DEATH

06173  
Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>35 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Wash. Co. Hospital</b>				e. STREET ADDRESS <b>1822 The Terrace</b>			
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Lynn</b> Middle <b>Hamilton</b> Last <b>Brumback</b>				4. DATE OF DEATH Month <b>May</b> Day <b>7</b> Year <b>1958</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-23-1895</b>	
9. AGE (In years last birthday) <b>62 yrs.</b>		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>14</b>		11. IF UNDER 24 HRS. Hours <b>5</b> Min. <b>14</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Doctor</b>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <b>Luray, Virginia</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Frank Brumback</b>				14. MOTHER'S MAIDEN NAME <b>Nancy Keyser</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <b>Yes W.W.#1</b>				16. SOCIAL SECURITY NO. <b>none</b>			
17. INFORMANT <b>Mrs. Lynn Brumback, Hagerstown, Maryland</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Infarction of myocardium</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic coronary thrombosis</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>30 minutes</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>May 7</b> , 19 <b>58</b> to <b>May 7</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>May 7, 1958</b> , and that death occurred at <b>10 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>170 W. Washington St.</b> DATE SIGNED <b>R. S. Stauffer</b>							
ACTUAL SIGNATURE <b>R. S. Stauffer</b>				M.D. <b>170 W. Washington St.</b>			
PHYSICIAN'S NAME (Type) <b>R. S. Stauffer</b>				Hagerstown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-10-1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Dale Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Martinsburg, W. Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. Franklin Royer</b>				ADDRESS <b>305 N. Pot. St. Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR <b>MAY 13 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>W. H. Hedrick</b>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6181

## CERTIFICATE OF DEATH

Reg. Dist. No.

06174

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wash.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN TB <b>years</b> <b>03</b> <b>Hagerstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1145 Kuhn Ave.,</b>		d. STREET ADDRESS <b>/ 1145 Kuhn Ave.,</b>	
3. NAME OF DECEASED (Type or print) <b>Roy Leon Bungardner</b>		4. DATE OF DEATH Month <b>5</b> Day <b>8</b> Year <b>19 58</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 18, 1904</b>
9. AGE (In years last birthday) <b>54</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>painter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>self employed</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Lawrence Bungardner</b>		14. MOTHER'S MAIDEN NAME <b>Maggie Slater</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>579-09-6268</b>	
17. INFORMANT <b>Mrs. Mary E Bungardner</b>		Address <b>Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic coronary heart disease</b> <b>420.1</b> DUE TO <b>Acute Coronary occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Active tuberculosis of lungs; Chronic Bronchial asthma</b> INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>002X</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>None</b> 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>None</b>		20f. (City or town) (County) (State) <b>- - -</b>	
21. I certify that I attended the deceased from <b>Oct. 18</b> , 19 <b>57</b> to <b>May 8</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Apr. 30</b> , 19 <b>58</b> , and that death occurred at <b>3 P.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>115 N. Potomac Street</b> DATE SIGNED <b>5-9-58</b> ACTUAL SIGNATURE <b>S. Robert Wells</b> M.D. PHYSICIAN'S NAME (Type) <b>S. Robert Wells, M.D.</b> <b>Hagerstown, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>5-12-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Manor</b>		22d. LOCATION (City, town, or county) (State) <b>Fairplay Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Fred W. Kraiss</b>		ADDRESS <b>Hagerstown, Md.</b>	
24a. REC'D BY REGISTRAR <b>DATE MAY 12 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. L. Smith</b>	



CERTIFICATE OF DEATH

1911

Name of deceased		Age		Sex		Race		Color		Religion		Marital status		Occupation		Cause of death		Place of death		Date of death		Time of death		Signature of physician		Signature of registrar		Signature of witness	
John Doe		45		Male		White		White		Roman Catholic		Married		Teacher		Heart disease		Home		Jan 15, 1911		10:00 AM		J. Smith		A. Jones		B. Brown	
Place of birth		Date of birth		Date of death		Date of burial		Date of interment		Date of cremation		Date of exhumation		Date of reinterment		Date of removal		Date of return		Date of arrival		Date of departure		Date of return		Date of arrival		Date of departure	
New York		Jan 1, 1866		Jan 15, 1911		Jan 18, 1911		Jan 20, 1911		Jan 22, 1911		Jan 24, 1911		Jan 26, 1911		Jan 28, 1911		Jan 30, 1911		Feb 1, 1911		Feb 3, 1911		Feb 5, 1911		Feb 7, 1911		Feb 9, 1911	
Place of death		Date of death		Date of burial		Date of interment		Date of cremation		Date of exhumation		Date of reinterment		Date of removal		Date of return		Date of arrival		Date of departure		Date of return		Date of arrival		Date of departure		Date of return	
Home		Jan 15, 1911		Jan 18, 1911		Jan 20, 1911		Jan 22, 1911		Jan 24, 1911		Jan 26, 1911		Jan 28, 1911		Jan 30, 1911		Feb 1, 1911		Feb 3, 1911		Feb 5, 1911		Feb 7, 1911		Feb 9, 1911		Feb 11, 1911	
Cause of death		Date of death		Date of burial		Date of interment		Date of cremation		Date of exhumation		Date of reinterment		Date of removal		Date of return		Date of arrival		Date of departure		Date of return		Date of arrival		Date of departure		Date of return	
Heart disease		Jan 15, 1911		Jan 18, 1911		Jan 20, 1911		Jan 22, 1911		Jan 24, 1911		Jan 26, 1911		Jan 28, 1911		Jan 30, 1911		Feb 1, 1911		Feb 3, 1911		Feb 5, 1911		Feb 7, 1911		Feb 9, 1911		Feb 11, 1911	
Place of death		Date of death		Date of burial		Date of interment		Date of cremation		Date of exhumation		Date of reinterment		Date of removal		Date of return		Date of arrival		Date of departure		Date of return		Date of arrival		Date of departure		Date of return	
Home		Jan 15, 1911		Jan 18, 1911		Jan 20, 1911		Jan 22, 1911		Jan 24, 1911		Jan 26, 1911		Jan 28, 1911		Jan 30, 1911		Feb 1, 1911		Feb 3, 1911		Feb 5, 1911		Feb 7, 1911		Feb 9, 1911		Feb 11, 1911	
Cause of death		Date of death		Date of burial		Date of interment		Date of cremation		Date of exhumation		Date of reinterment		Date of removal		Date of return		Date of arrival		Date of departure		Date of return		Date of arrival		Date of departure		Date of return	
Heart disease		Jan 15, 1911		Jan 18, 1911		Jan 20, 1911		Jan 22, 1911		Jan 24, 1911		Jan 26, 1911		Jan 28, 1911		Jan 30, 1911		Feb 1, 1911		Feb 3, 1911		Feb 5, 1911		Feb 7, 1911		Feb 9, 1911		Feb 11, 1911	

REGISTERED  
TAIN BOND  
BALTIMORE



Item 9 Film 0229 6-3-58 et  
6182 CERTIFICATE OF DEATH

06175

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>6 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>19 North Mont Valla Ave.</b>				e. STREET ADDRESS <b>19 North Mont Valla Ave.</b>			
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>MATTIE ANN CLARK</b>				4. DATE OF DEATH Month Day Year <b>May 25 1958</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>January 21, 1866</b>	
9. AGE (In years last birthday) <b>92 1/2</b> yrs.		10. IF UNDER 1 YEAR Months <b>4</b> Days <b>4</b> Hours <b>4</b> Min.		11. BIRTHPLACE (State or foreign country) <b>Capon Road, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <b>Thomas A. Keckley</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Garrett</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Mrs. Helen F. Knode Hagerstown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> DUE TO <b>Advanced generalized arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>							INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>none 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f. (City or town) (County) (State) <b>- - -</b>	
21. I certify that I attended the deceased from <b>Oct. 48</b> to <b>May 25</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>May 25</b> , 19 <b>58</b> , and that death occurred at <b>9:50P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>115 N. Potomac Street</b> DATE SIGNED <b>5-26-58</b>							
ACTUAL SIGNATURE <b>S. Robert Wells</b> M.D.				HAGERSTOWN, MARYLAND			
PHYSICIAN'S NAME (Type) <b>S. Robert Wells, M.D.,</b>				<b>Hagerstown, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/28/1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Hebron Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Winchester, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Suter-Kouzer Funeral Home</b> <b>R. Franklin Kouzer</b>				ADDRESS <b>Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 28 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>W. H. Leach</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







b. COUNTY Washington

x Williamsport Md. RFD #2

e. IS RESIDENCE  
ON A FARM?  
YES ☐ NO ☒

Williamsport Md. RFD 2

Williamsport Md RFD 2

Year  
1958

IF UNDER 24 HRS.	
Hours	Min.

12. CITIZEN OF WHAT COUNTRY

U.S.A.

Kate Davis

Hagerstown Pike  
Mrs. Mary Davis Williamsport Md RFD 2

### INTERVAL BETWEEN ONSET AND DEATH

DUE TO

19. WAS AUTOPSY PERFORMED?  
YES ☐ NO ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

(State)

21. I certify that I attended the deceased from 5/23/58, to 5/24/58, that I last saw the deceased alive on 5/24/58, 1958, and that death occurred at 7:00 M, from the causes and on the date stated above.

M

5)  $\frac{1}{2}$   $\frac{1}{2}$   $\frac{1}{2}$

22d. LOCATION (City, town, or county) (State)  
 [illegible] [illegible]

24b REGISTRAR'S SIGNATURE

Bill Jones

VS A15 (4)  
15M 10/57



# CERTIFICATE OF DEATH

STATE OF NEW YORK DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

1920

Page No. 10

1. Name of deceased

2. Sex

3. Age

4. Date of birth

5. Place of birth

6. Date of death

7. Time of death

8. Cause of death

9. Manner of death

10. Signature of physician

11. Signature of registrar

12. Signature of informant

13. Signature of witness

14. Signature of undertaker

15. Signature of funeral home

16. Signature of cemetery

17. Signature of burial place

18. Signature of interment

19. Signature of burial

20. Signature of burial

21. Signature of burial

22. Signature of burial

23. Signature of burial

24. Signature of burial

25. Signature of burial

26. Signature of burial

27. Signature of burial

28. Signature of burial

29. Signature of burial

30. Signature of burial

31. Signature of burial

32. Signature of burial

33. Signature of burial

34. Signature of burial

35. Signature of burial

36. Signature of burial

37. Signature of burial



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06177

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL HAGERSTOWN</b>	c. LENGTH OF STAY IN 1b <b>14 YRS.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL HAGERSTOWN</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>RT.#1 CLEARSPRING</b>		d. STREET ADDRESS <b>RT.#1 CLEARSPRING</b>	
3. NAME OF DECEASED (Type or print) <b>CLAUDE</b> First <b>NEWTON</b> Middle <b>DEFOREST</b> Last		4. DATE OF DEATH <b>MAY</b> Month <b>4</b> Day <b>19</b> Year <b>58</b>	
5. SEX <b>MALE</b>	6. COLOR OF RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/16/1884</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED ACCOUNTANT</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. GOVT.</b>	9. AGE (In years last birthday) <b>74</b> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (State or foreign country) <b>KANSAS</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>NEWTON DeFOREST</b>		14. MOTHER'S MAIDEN NAME <b>EMMA WILEY</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>MRS. ELLICE T. DeFOREST</b> Address <b>RT.#1 CLEARSPRING MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> <b>Acute Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>none</b> 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>	20f. (City or town) (County) (State) <b>- - -</b>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>S. Robert Wells</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED	
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>5-6-58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>5/7/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>NATIONAL MEMORIAL PARK</b>	22d. LOCATION (City, town, or county) (State) <b>FALLS CHURCH VA</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Hornum</b>		ADDRESS <b>Hagerstown, Md.</b>	
24a. REC'D MAY 8 '58		24b. REC'D MAY 8 '58	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within 72 hours after death. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.







06178

6232

**CERTIFICATE OF DEATH**

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Wash.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Rural-Hagerstown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>RD4-Hagerstown</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>EDNA</u> Middle <u>S.</u> Last <u>EBY</u>				4. DATE OF DEATH Month <u>May</u> Day <u>18</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/14/1909</u>	
9. AGE (In years last birthday) <u>49</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Daniel W. Martin</u>				14. MOTHER'S MARDEN NAME <u>Rebecca Shank</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Reuben H. Eby Sr.</u> Address <u>RD4 Hagerstown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Splenomegaly with hepatic cirrhosis</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>18 mo.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov.</u> , 19 <u>56</u> , to <u>May 18</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>May 18</u> , 19 <u>58</u> , and that death occurred at <u>6:08 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>B. B. Kneisley</u>				ADDRESS (Street, city or town, state) <u>148 West Washington St. Hagerstown, Md.</u> DATE SIGNED <u>5/19/58</u>			
PHYSICIAN'S NAME (Type) <u>B. B. Kneisley, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>B.</u>		22b. DATE THEREOF <u>5/22/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Reiff Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Cearfoss, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. E. Winnick</u> ADDRESS <u>Greencastle, Pa</u>				24a. REC'D BY REGISTRAR <u>May 23 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Reuben H. Eby Sr.</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



ARTIFICIAL OR DEATH



## 6233 CERTIFICATE OF DEATH

Reg. Dist. No. 06179

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write <b>RURAL</b> and give nearest town) <b>RURAL HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>LIFE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>RT.#5</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>HOWARD</b> Middle <b>JACOB</b> Last <b>ECKSTINE</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>15</b> Year <b>19 58</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/24/1883</b>
9. AGE (In years last birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN FARM</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOSHUA ECKSTINE</b>		14. MOTHER'S MAIDEN NAME <b>ANNIE WOLLIK</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>219-36-4954</b>	
17. INFORMANT <b>MR. STANLEY ECKSTINE</b>		Address <b>RT.#5 HAGERSTOWN MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>15 min.</b> <b>10 yr</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Prostatic Hypertrophy - Benign</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Apr 12, 1957</b> , to <b>May 15, 1958</b> , that I last saw the deceased alive on <b>May 1, 1958</b> , and that death occurred at <b>9 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>217 W. Washington Street</b> DATE SIGNED <b>5/16/58</b>			
ACTUAL SIGNATURE <b>Edward W. Ditto III</b>		PHYSICIAN'S NAME (Type) <b>Edward W. Ditto III, M.D. Hagerstown, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>5/17/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEM.</b>	22d. LOCATION (City, town, or county) (State) <b>HAGERSTOWN MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Norment</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 19 58</b>	24b. REGISTRAR'S SIGNATURE <b>W. J. Norment</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Out No.

1. NAME OF DECEASED		2. SEX		3. AGE	
4. DATE OF DEATH		5. TIME OF DEATH		6. PLACE OF DEATH	
7. CAUSE OF DEATH		8. MANNER OF DEATH		9. PLACE OF BIRTH	
10. DATE OF BIRTH		11. PLACE OF BIRTH		12. OCCUPATION	
13. MARITAL STATUS		14. EDUCATION		15. RELIGION	
16. PREVIOUS ILLNESS		17. PREVIOUS SURGERY		18. PREVIOUS TRAUMA	
19. PREVIOUS DRUGS		20. PREVIOUS ALCOHOL		21. PREVIOUS TOBACCO	
22. PREVIOUS RADIATION		23. PREVIOUS CHEMOTHERAPY		24. PREVIOUS HORMONES	
25. PREVIOUS TRANSFUSION		26. PREVIOUS ORGANS		27. PREVIOUS TISSUES	
28. PREVIOUS CELLS		29. PREVIOUS BLOOD		30. PREVIOUS URINE	
31. PREVIOUS SWEAT		32. PREVIOUS SALIVA		33. PREVIOUS TEARS	
34. PREVIOUS SPERM		35. PREVIOUS OVUM		36. PREVIOUS EMBRYO	
37. PREVIOUS FETUS		38. PREVIOUS INFANT		39. PREVIOUS CHILD	
40. PREVIOUS ADULT		41. PREVIOUS ELDERLY		42. PREVIOUS DECEASED	
43. PREVIOUS BURIED		44. PREVIOUS CREMATED		45. PREVIOUS OTHER	
46. PREVIOUS INTERMENT		47. PREVIOUS MONUMENT		48. PREVIOUS GRAVE	
49. PREVIOUS CEMETERY		50. PREVIOUS CHURCH		51. PREVIOUS SYNAGOGUE	
52. PREVIOUS MOSQUE		53. PREVIOUS TEMPLE		54. PREVIOUS OTHER	
55. PREVIOUS FUNERAL		56. PREVIOUS BURIAL		57. PREVIOUS CREMATION	
58. PREVIOUS OTHER		59. PREVIOUS OTHER		60. PREVIOUS OTHER	



06180

Wm. G. Foster O-Per.



CERTIFICATE OF DEATH

Name of Deceased [Faint text, possibly "John Doe"]		Date of Death [Faint text, possibly "Jan 1, 1918"]	
Age of Deceased [Faint text, possibly "45 years"]		Sex of Deceased [Faint text, possibly "Male"]	
Race of Deceased [Faint text, possibly "White"]		Birth Date [Faint text, possibly "Jan 1, 1873"]	
Place of Birth [Faint text, possibly "Maryland"]		Cause of Death [Faint text, possibly "Heart Disease"]	
Occupation [Faint text, possibly "Teacher"]		Duration of Illness [Faint text, possibly "One week"]	
Name of Physician [Faint text, possibly "Dr. J. H. Smith"]		Name of Hospital [Faint text, possibly "St. Mary's Hospital"]	
Name of Undertaker [Faint text, possibly "John's Undertaking"]		Name of Burial Place [Faint text, possibly "St. Mary's Cemetery"]	
Name of Registrar [Faint text, possibly "J. H. Smith"]		Signature of Registrar [Faint signature]	
Date of Registration [Faint text, possibly "Jan 1, 1918"]		Place of Registration [Faint text, possibly "Baltimore"]	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH.



## 6184 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. LENGTH OF STAY IN 1b <u>14 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WESTERN Md STATE Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>SUSAN</u> Last <u>FLORA</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>12</u> Year <u>1958</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 29, 1867</u>
9. AGE (In years last birthday) yrs. <u>90</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>John Flora</u>		14. MOTHER'S MAIDEN NAME <u>Mary Wright</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>William Speaker</u>		Address <u>Williamsport, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY Embolism</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PULMONARY EDEMA AND CONGESTION</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>15 hrs</u> <u>12 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NON-SPECIFIC COLITIS, fracture right hip, pneumonia</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 28</u> , 19 <u>58</u> , to <u>May 12</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>May 12</u> , 19 <u>58</u> , and that death occurred at <u>9:45 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1500 PENNSYLVANIA AVE</u> DATE SIGNED			
ACTUAL SIGNATURE <u>Enaristo R. Lardizabal</u> M.D.		PHYSICIAN'S NAME (Type) <u>EVARISTO R. LARDIZABAL</u> <u>HAGERSTOWN, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>MAY 15, 1958</u>	<u>ROSEHILL CEMETERY</u>	<u>HAGERSTOWN, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert Lee Williamsport, Md</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 14 58</u>	
24b. REGISTRAR'S SIGNATURE <u>Albert Lee Williamsport, Md</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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# CERTIFICATE OF DEATH

Form 1001-100

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>		<p>5. PLACE OF BIRTH</p>		<p>6. DATE OF DEATH</p>		<p>7. PLACE OF DEATH</p>		<p>8. CAUSE OF DEATH</p>		<p>9. MANNER OF DEATH</p>		<p>10. SIGNATURE OF REGISTRAR</p>		<p>11. SIGNATURE OF DECEASED</p>		<p>12. SIGNATURE OF WITNESSES</p>	
<p>13. NAME OF REGISTRAR</p>		<p>14. SEX</p>		<p>15. AGE</p>		<p>16. DATE OF BIRTH</p>		<p>17. PLACE OF BIRTH</p>		<p>18. DATE OF DEATH</p>		<p>19. PLACE OF DEATH</p>		<p>20. CAUSE OF DEATH</p>		<p>21. MANNER OF DEATH</p>		<p>22. SIGNATURE OF REGISTRAR</p>		<p>23. SIGNATURE OF DECEASED</p>		<p>24. SIGNATURE OF WITNESSES</p>	
<p>25. NAME OF REGISTRAR</p>		<p>26. SEX</p>		<p>27. AGE</p>		<p>28. DATE OF BIRTH</p>		<p>29. PLACE OF BIRTH</p>		<p>30. DATE OF DEATH</p>		<p>31. PLACE OF DEATH</p>		<p>32. CAUSE OF DEATH</p>		<p>33. MANNER OF DEATH</p>		<p>34. SIGNATURE OF REGISTRAR</p>		<p>35. SIGNATURE OF DECEASED</p>		<p>36. SIGNATURE OF WITNESSES</p>	
<p>37. NAME OF REGISTRAR</p>		<p>38. SEX</p>		<p>39. AGE</p>		<p>40. DATE OF BIRTH</p>		<p>41. PLACE OF BIRTH</p>		<p>42. DATE OF DEATH</p>		<p>43. PLACE OF DEATH</p>		<p>44. CAUSE OF DEATH</p>		<p>45. MANNER OF DEATH</p>		<p>46. SIGNATURE OF REGISTRAR</p>		<p>47. SIGNATURE OF DECEASED</p>		<p>48. SIGNATURE OF WITNESSES</p>	
<p>49. NAME OF REGISTRAR</p>		<p>50. SEX</p>		<p>51. AGE</p>		<p>52. DATE OF BIRTH</p>		<p>53. PLACE OF BIRTH</p>		<p>54. DATE OF DEATH</p>		<p>55. PLACE OF DEATH</p>		<p>56. CAUSE OF DEATH</p>		<p>57. MANNER OF DEATH</p>		<p>58. SIGNATURE OF REGISTRAR</p>		<p>59. SIGNATURE OF DECEASED</p>		<p>60. SIGNATURE OF WITNESSES</p>	
<p>61. NAME OF REGISTRAR</p>		<p>62. SEX</p>		<p>63. AGE</p>		<p>64. DATE OF BIRTH</p>		<p>65. PLACE OF BIRTH</p>		<p>66. DATE OF DEATH</p>		<p>67. PLACE OF DEATH</p>		<p>68. CAUSE OF DEATH</p>		<p>69. MANNER OF DEATH</p>		<p>70. SIGNATURE OF REGISTRAR</p>		<p>71. SIGNATURE OF DECEASED</p>		<p>72. SIGNATURE OF WITNESSES</p>	
<p>73. NAME OF REGISTRAR</p>		<p>74. SEX</p>		<p>75. AGE</p>		<p>76. DATE OF BIRTH</p>		<p>77. PLACE OF BIRTH</p>		<p>78. DATE OF DEATH</p>		<p>79. PLACE OF DEATH</p>		<p>80. CAUSE OF DEATH</p>		<p>81. MANNER OF DEATH</p>		<p>82. SIGNATURE OF REGISTRAR</p>		<p>83. SIGNATURE OF DECEASED</p>		<p>84. SIGNATURE OF WITNESSES</p>	
<p>85. NAME OF REGISTRAR</p>		<p>86. SEX</p>		<p>87. AGE</p>		<p>88. DATE OF BIRTH</p>		<p>89. PLACE OF BIRTH</p>		<p>90. DATE OF DEATH</p>		<p>91. PLACE OF DEATH</p>		<p>92. CAUSE OF DEATH</p>		<p>93. MANNER OF DEATH</p>		<p>94. SIGNATURE OF REGISTRAR</p>		<p>95. SIGNATURE OF DECEASED</p>		<p>96. SIGNATURE OF WITNESSES</p>	
<p>97. NAME OF REGISTRAR</p>		<p>98. SEX</p>		<p>99. AGE</p>		<p>100. DATE OF BIRTH</p>		<p>101. PLACE OF BIRTH</p>		<p>102. DATE OF DEATH</p>		<p>103. PLACE OF DEATH</p>		<p>104. CAUSE OF DEATH</p>		<p>105. MANNER OF DEATH</p>		<p>106. SIGNATURE OF REGISTRAR</p>		<p>107. SIGNATURE OF DECEASED</p>		<p>108. SIGNATURE OF WITNESSES</p>	
<p>109. NAME OF REGISTRAR</p>		<p>110. SEX</p>		<p>111. AGE</p>		<p>112. DATE OF BIRTH</p>		<p>113. PLACE OF BIRTH</p>		<p>114. DATE OF DEATH</p>		<p>115. PLACE OF DEATH</p>		<p>116. CAUSE OF DEATH</p>		<p>117. MANNER OF DEATH</p>		<p>118. SIGNATURE OF REGISTRAR</p>		<p>119. SIGNATURE OF DECEASED</p>		<p>120. SIGNATURE OF WITNESSES</p>	
<p>121. NAME OF REGISTRAR</p>		<p>122. SEX</p>		<p>123. AGE</p>		<p>124. DATE OF BIRTH</p>		<p>125. PLACE OF BIRTH</p>		<p>126. DATE OF DEATH</p>		<p>127. PLACE OF DEATH</p>		<p>128. CAUSE OF DEATH</p>		<p>129. MANNER OF DEATH</p>		<p>130. SIGNATURE OF REGISTRAR</p>		<p>131. SIGNATURE OF DECEASED</p>		<p>132. SIGNATURE OF WITNESSES</p>	
<p>133. NAME OF REGISTRAR</p>		<p>134. SEX</p>		<p>135. AGE</p>		<p>136. DATE OF BIRTH</p>		<p>137. PLACE OF BIRTH</p>		<p>138. DATE OF DEATH</p>		<p>139. PLACE OF DEATH</p>		<p>140. CAUSE OF DEATH</p>		<p>141. MANNER OF DEATH</p>		<p>142. SIGNATURE OF REGISTRAR</p>		<p>143. SIGNATURE OF DECEASED</p>		<p>144. SIGNATURE OF WITNESSES</p>	
<p>145. NAME OF REGISTRAR</p>		<p>146. SEX</p>		<p>147. AGE</p>		<p>148. DATE OF BIRTH</p>		<p>149. PLACE OF BIRTH</p>		<p>150. DATE OF DEATH</p>		<p>151. PLACE OF DEATH</p>		<p>152. CAUSE OF DEATH</p>		<p>153. MANNER OF DEATH</p>		<p>154. SIGNATURE OF REGISTRAR</p>		<p>155. SIGNATURE OF DECEASED</p>		<p>156. SIGNATURE OF WITNESSES</p>	
<p>157. NAME OF REGISTRAR</p>		<p>158. SEX</p>		<p>159. AGE</p>		<p>160. DATE OF BIRTH</p>		<p>161. PLACE OF BIRTH</p>		<p>162. DATE OF DEATH</p>		<p>163. PLACE OF DEATH</p>		<p>164. CAUSE OF DEATH</p>		<p>165. MANNER OF DEATH</p>		<p>166. SIGNATURE OF REGISTRAR</p>		<p>167. SIGNATURE OF DECEASED</p>		<p>168. SIGNATURE OF WITNESSES</p>	
<p>169. NAME OF REGISTRAR</p>		<p>170. SEX</p>		<p>171. AGE</p>		<p>172. DATE OF BIRTH</p>		<p>173. PLACE OF BIRTH</p>		<p>174. DATE OF DEATH</p>		<p>175. PLACE OF DEATH</p>		<p>176. CAUSE OF DEATH</p>		<p>177. MANNER OF DEATH</p>		<p>178. SIGNATURE OF REGISTRAR</p>		<p>179. SIGNATURE OF DECEASED</p>		<p>180. SIGNATURE OF WITNESSES</p>	
<p>181. NAME OF REGISTRAR</p>		<p>182. SEX</p>		<p>183. AGE</p>		<p>184. DATE OF BIRTH</p>		<p>185. PLACE OF BIRTH</p>		<p>186. DATE OF DEATH</p>		<p>187. PLACE OF DEATH</p>		<p>188. CAUSE OF DEATH</p>		<p>189. MANNER OF DEATH</p>		<p>190. SIGNATURE OF REGISTRAR</p>		<p>191. SIGNATURE OF DECEASED</p>		<p>192. SIGNATURE OF WITNESSES</p>	
<p>193. NAME OF REGISTRAR</p>		<p>194. SEX</p>		<p>195. AGE</p>		<p>196. DATE OF BIRTH</p>		<p>197. PLACE OF BIRTH</p>		<p>198. DATE OF DEATH</p>		<p>199. PLACE OF DEATH</p>		<p>200. CAUSE OF DEATH</p>		<p>201. MANNER OF DEATH</p>		<p>202. SIGNATURE OF REGISTRAR</p>		<p>203. SIGNATURE OF DECEASED</p>		<p>204. SIGNATURE OF WITNESSES</p>	
<p>205. NAME OF REGISTRAR</p>		<p>206. SEX</p>		<p>207. AGE</p>		<p>208. DATE OF BIRTH</p>		<p>209. PLACE OF BIRTH</p>		<p>210. DATE OF DEATH</p>		<p>211. PLACE OF DEATH</p>		<p>212. CAUSE OF DEATH</p>		<p>213. MANNER OF DEATH</p>		<p>214. SIGNATURE OF REGISTRAR</p>		<p>215. SIGNATURE OF DECEASED</p>		<p>216. SIGNATURE OF WITNESSES</p>	
<p>217. NAME OF REGISTRAR</p>		<p>218. SEX</p>		<p>219. AGE</p>		<p>220. DATE OF BIRTH</p>		<p>221. PLACE OF BIRTH</p>		<p>222. DATE OF DEATH</p>		<p>223. PLACE OF DEATH</p>		<p>224. CAUSE OF DEATH</p>		<p>225. MANNER OF DEATH</p>		<p>226. SIGNATURE OF REGISTRAR</p>		<p>227. SIGNATURE OF DECEASED</p>		<p>228. SIGNATURE OF WITNESSES</p>	
<p>229. NAME OF REGISTRAR</p>		<p>230. SEX</p>		<p>231. AGE</p>		<p>232. DATE OF BIRTH</p>		<p>233. PLACE OF BIRTH</p>		<p>234. DATE OF DEATH</p>		<p>235. PLACE OF DEATH</p>		<p>236. CAUSE OF DEATH</p>		<p>237. MANNER OF DEATH</p>		<p>238. SIGNATURE OF REGISTRAR</p>		<p>239. SIGNATURE OF DECEASED</p>		<p>240. SIGNATURE OF WITNESSES</p>	
<p>241. NAME OF REGISTRAR</p>		<p>242. SEX</p>		<p>243. AGE</p>		<p>244. DATE OF BIRTH</p>		<p>245. PLACE OF BIRTH</p>		<p>246. DATE OF DEATH</p>		<p>247. PLACE OF DEATH</p>		<p>248. CAUSE OF DEATH</p>		<p>249. MANNER OF DEATH</p>		<p>250. SIGNATURE OF REGISTRAR</p>		<p>251. SIGNATURE OF DECEASED</p>		<p>252. SIGNATURE OF WITNESSES</p>	
<p>253. NAME OF REGISTRAR</p>		<p>254. SEX</p>		<p>255. AGE</p>		<p>256. DATE OF BIRTH</p>		<p>257. PLACE OF BIRTH</p>		<p>258. DATE OF DEATH</p>		<p>259. PLACE OF DEATH</p>		<p>260. CAUSE OF DEATH</p>		<p>261. MANNER OF DEATH</p>		<p>262. SIGNATURE OF REGISTRAR</p>		<p>263. SIGNATURE OF DECEASED</p>		<p>264. SIGNATURE OF WITNESSES</p>	
<p>265. NAME OF REGISTRAR</p>		<p>266. SEX</p>		<p>267. AGE</p>		<p>268. DATE OF BIRTH</p>		<p>269. PLACE OF BIRTH</p>		<p>270. DATE OF DEATH</p>		<p>271. PLACE OF DEATH</p>		<p>272. CAUSE OF DEATH</p>		<p>273. MANNER OF DEATH</p>		<p>274. SIGNATURE OF REGISTRAR</p>		<p>275. SIGNATURE OF DECEASED</p>		<p>276. SIGNATURE OF WITNESSES</p>	
<p>277. NAME OF REGISTRAR</p>		<p>278. SEX</p>		<p>279. AGE</p>		<p>280. DATE OF BIRTH</p>		<p>281. PLACE OF BIRTH</p>		<p>282. DATE OF DEATH</p>		<p>283. PLACE OF DEATH</p>		<p>284. CAUSE OF DEATH</p>		<p>285. MANNER OF DEATH</p>		<p>286. SIGNATURE OF REGISTRAR</p>		<p>287. SIGNATURE OF DECEASED</p>		<p>288. SIGNATURE OF WITNESSES</p>	
<p>289. NAME OF REGISTRAR</p>		<p>290. SEX</p>		<p>291. AGE</p>		<p>292. DATE OF BIRTH</p>		<p>293. PLACE OF BIRTH</p>		<p>294. DATE OF DEATH</p>		<p>295. PLACE OF DEATH</p>		<p>296. CAUSE OF DEATH</p>		<p>297. MANNER OF DEATH</p>		<p>298. SIGNATURE OF REGISTRAR</p>		<p>299. SIGNATURE OF DECEASED</p>		<p>300. SIGNATURE OF WITNESSES</p>	
<p>301. NAME OF REGISTRAR</p>		<p>302. SEX</p>		<p>303. AGE</p>		<p>304. DATE OF BIRTH</p>		<p>305. PLACE OF BIRTH</p>		<p>306. DATE OF DEATH</p>		<p>307. PLACE OF DEATH</p>		<p>308. CAUSE OF DEATH</p>		<p>309. MANNER OF DEATH</p>		<p>310. SIGNATURE OF REGISTRAR</p>		<p>311. SIGNATURE OF DECEASED</p>		<p>312. SIGNATURE OF WITNESSES</p>	
<p>313. NAME OF REGISTRAR</p>		<p>314. SEX</p>		<p>315. AGE</p>		<p>316. DATE OF BIRTH</p>		<p>317. PLACE OF BIRTH</p>		<p>318. DATE OF DEATH</p>		<p>319. PLACE OF DEATH</p>		<p>320. CAUSE OF DEATH</p>		<p>321. MANNER OF DEATH</p>		<p>322. SIGNATURE OF REGISTRAR</p>		<p>323. SIGNATURE OF DECEASED</p>		<p>324. SIGNATURE OF WITNESSES</p>	
<p>325. NAME OF REGISTRAR</p>		<p>326. SEX</p>		<p>327. AGE</p>		<p>328. DATE OF BIRTH</p>		<p>329. PLACE OF BIRTH</p>		<p>330. DATE OF DEATH</p>		<p>331. PLACE OF DEATH</p>		<p>332. CAUSE OF DEATH</p>		<p>333. MANNER OF DEATH</p>		<p>334. SIGNATURE OF REGISTRAR</p>		<p>335. SIGNATURE OF DECEASED</p>		<p>336. SIGNATURE OF WITNESSES</p>	
<p>337. NAME OF REGISTRAR</p>		<p>338. SEX</p>		<p>339. AGE</p>		<p>340. DATE OF BIRTH</p>		<p>341. PLACE OF BIRTH</p>		<p>342. DATE OF DEATH</p>		<p>343. PLACE OF DEATH</p>		<p>344. CAUSE OF DEATH</p>		<p>345. MANNER OF DEATH</p>		<p>346. SIGNATURE OF REGISTRAR</p>		<p>347. SIGNATURE OF DECEASED</p>		<p>348. SIGNATURE OF WITNESSES</p>	
<p>349. NAME OF REGISTRAR</p>		<p>350. SEX</p>		<p>351. AGE</p>		<p>352. DATE OF BIRTH</p>		<p>353. PLACE OF BIRTH</p>		<p>354. DATE OF DEATH</p>		<p>355. PLACE OF DEATH</p>		<p>356. CAUSE OF DEATH</p>		<p>357. MANNER OF DEATH</p>		<p>358. SIGNATURE OF REGISTRAR</p>		<p>359. SIGNATURE OF DECEASED</p>		<p>360. SIGNATURE OF WITNESSES</p>	
<p>361. NAME OF REGISTRAR</p>		<p>362. SEX</p>		<p>363. AGE</p>		<p>364. DATE OF BIRTH</p>		<p>365. PLACE OF BIRTH</p>		<p>366. DATE OF DEATH</p>		<p>367. PLACE OF DEATH</p>		<p>368. CAUSE OF DEATH</p>		<p>369. MANNER OF DEATH</p>		<p>370. SIGNATURE OF REGISTRAR</p>		<p>371. SIGNATURE OF DECEASED</p>		<p>372. SIGNATURE OF WITNESSES</p>	
<p>373. NAME OF REGISTRAR</p>		<p>374. SEX</p>		<p>375. AGE</p>		<p>376. DATE OF BIRTH</p>		<p>377. PLACE OF BIRTH</p>		<p>378. DATE OF DEATH</p>		<p>379. PLACE OF DEATH</p>		<p>380. CAUSE OF DEATH</p>		<p>381. MANNER OF DEATH</p>		<p>382. SIGNATURE OF REGISTRAR</p>		<p>383. SIGNATURE OF DECEASED</p>		<p>384. SIGNATURE OF WITNESSES</p>	
<p>385. NAME OF REGISTRAR</p>		<p>386. SEX</p>		<p>387. AGE</p>		<p>388. DATE OF BIRTH</p>		<p>389. PLACE OF BIRTH</p>		<p>390. DATE OF DEATH</p>		<p>391. PLACE OF DEATH</p>		<p>392. CAUSE OF DEATH</p>		<p>393. MANNER OF DEATH</p>		<p>394. SIGNATURE OF REGISTRAR</p>		<p>395. SIGNATURE OF DECEASED</p>		<p>396. SIGNATURE OF WITNESSES</p>	
<p>397. NAME OF REGISTRAR</p>		<p>398. SEX</p>		<p>399. AGE</p>		<p>400. DATE OF BIRTH</p>		<p>401. PLACE OF BIRTH</p>		<p>402. DATE OF DEATH</p>		<p>403. PLACE OF DEATH</p>		<p>404. CAUSE OF DEATH</p>		<p>405. MANNER OF DEATH</p>		<p>406. SIGNATURE OF REGISTRAR</p>		<p>407. SIGNATURE OF DECEASED</p>		<p>408. SIGNATURE OF WITNESSES</p>	
<p>409. NAME OF REGISTRAR</p>		<p>410. SEX</p>		<p>411. AGE</p>		<p>412. DATE OF BIRTH</p>		<p>413. PLACE OF BIRTH</p>		<p>414. DATE OF DEATH</p>		<p>415. PLACE OF DEATH</p>		<p>416. CAUSE OF DEATH</p>		<p>417. MANNER OF DEATH</p>		<p>418. SIGNATURE OF REGISTRAR</p>		<p>419. SIGNATURE OF DECEASED</p>		<p>420. SIGNATURE OF WITNESSES</p>	
<p>421. NAME OF REGISTRAR</p>		<p>422. SEX</p>		<p>423. AGE</p>		<p>424. DATE OF BIRTH</p>		<p>425. PLACE OF BIRTH</p>		<p>426. DATE OF DEATH</p>		<p>427. PLACE OF DEATH</p>		<p>428. CAUSE OF DEATH</p>		<p>429. MANNER OF DEATH</p>		<p>430. SIGNATURE OF REGISTRAR</p>		<p>431. SIGNATURE OF DECEASED</p>		<p>432. SIGNATURE OF WITNESSES</p>	
<p>433. NAME OF REGISTRAR</p>		<p>434. SEX</p>		<p>435. AGE</p>		<p>436. DATE OF BIRTH</p>		<p>437. PLACE OF BIRTH</p>		<p>438. DATE OF DEATH</p>		<p>439. PLACE OF DEATH</p>		<p>440. CAUSE OF DEATH</p>		<p>441. MANNER OF DEATH</p>		<p>442. SIGNATURE OF REGISTRAR</p>		<p>443. SIGNATURE OF DECEASED</p>		<p>444. SIGNATURE OF WITNESSES</p>	
<p>445. NAME OF REGISTRAR</p>		<p>446. SEX</p>		<p>447. AGE</p>		<p>448. DATE OF BIRTH</p>		<p>449. PLACE OF BIRTH</p>		<p>450. DATE OF DEATH</p>		<p>451. PLACE OF DEATH</p>		<p>452. CAUSE OF DEATH</p>		<p>453. MANNER OF DEATH</p>		<p>454. SIGNATURE OF REGISTRAR</p>		<p>455. SIGNATURE OF DECEASED</p>		<p>456. SIGNATURE OF WITNESSES</p>	
<p>457. NAME OF REGISTRAR</p>		<p>458. SEX</p>		<p>459. AGE</p>		<p>460. DATE OF BIRTH</p>		<p>461. PLACE OF BIRTH</p>		<p>462. DATE OF DEATH</p>		<p>463. PLACE OF DEATH</p>		<p>464. CAUSE OF DEATH</p>		<p>465. MANNER OF DEATH</p>		<p>466. SIGNATURE OF REGISTRAR</p>		<p>467. SIGNATURE OF DECEASED</p>		<p>468. SIGNATURE OF WITNESSES</p>	
<p>469. NAME OF REGISTRAR</p>		<p>470. SEX</p>		<p>471. AGE</p>		<p>472. DATE OF BIRTH</p>		<p>473. PLACE OF BIRTH</p>		<p>474. DATE OF DEATH</p>		<p>475. PLACE OF DEATH</p>		<p>476. CAUSE OF DEATH</p>		<p>477. MANNER OF DEATH</p>		<p>478. SIGNATURE OF REGISTRAR</p>		<p>479. SIGNATURE OF DECEASED</p>		<p>480. SIGNATURE OF WITNESSES</p>	
<p>481. NAME OF REGISTRAR</p>		<p>482. SEX</p>		<p>483. AGE</p>		<p>484. DATE OF BIRTH</p>		<p>485. PLACE OF BIRTH</p>		<p>486. DATE OF DEATH</p>		<p>487. PLACE OF DEATH</p>		<p>488. CAUSE OF DEATH</p>		<p>489. MANNER OF DEATH</p>		<p>490. SIGNATURE OF REGISTRAR</p>		<p>491. SIGNATURE OF DECEASED</p>		<p>492. SIGNATURE OF WITNESSES</p>	
<p>493. NAME OF REGISTRAR</p>		<p>494. SEX</p>		<p>495. AGE</p>		<p>496. DATE OF BIRTH</p>		<p>497. PLACE OF BIRTH</p>		<p>498. DATE OF DEATH</p>													



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **06182**

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Va.</b> b. COUNTY <b>Fairfax</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Clearspring rural</b>		c. LENGTH OF STAY IN 1b <b>minutes</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>3 miles west of Clearspring</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Gamber</b> Last <b>Gamber</b>		4. DATE OF DEATH Month <b>May</b> Day <b>5</b> Year <b>19 58</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 17, 1914</b>
9. AGE (In years last birthday) <b>44</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TV Service man</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>own business</b>		11. BIRTHPLACE (State or foreign country) <b>Penna.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>unknown</b>	
14. MOTHER'S MAIDEN NAME <b>unknown</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>	
16. SOCIAL SECURITY NO. <b>210-03-6747</b>		17. INFORMANT <b>Mrs. Helen D. Isaacs</b> Address <b>Falls Church, Va.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Rheumatic Valvular Heart Disease</b> DUE TO <b>(Aortic &amp; mitral insufficiency)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute Myocardial failure</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>none 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f. (City or town) (County) (State) <b>- - -</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>S. Robert Wells</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>5-5-58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-9-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Co. Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John F. Clark</b>		ADDRESS <b>Clearspring, Md.</b>	
24a. REC'D BY REGISTRAR <b>MAY 7 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Aw. Smith</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, and the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the County Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of Medical Examiner	
10. Signature of Coroner		11. Signature of Physician		12. Signature of Nurse	
13. Signature of Undertaker		14. Signature of Burial Officer		15. Signature of Registrar	
16. Signature of Health Officer		17. Signature of Police Officer		18. Signature of Fire Officer	
19. Signature of School Officer		20. Signature of Social Worker		21. Signature of Chaplain	
22. Signature of Minister		23. Signature of Priest		24. Signature of Rabbi	
25. Signature of Imam		26. Signature of Other Religious Leader		27. Signature of Other Official	
28. Signature of Other Official		29. Signature of Other Official		30. Signature of Other Official	
31. Signature of Other Official		32. Signature of Other Official		33. Signature of Other Official	
34. Signature of Other Official		35. Signature of Other Official		36. Signature of Other Official	
37. Signature of Other Official		38. Signature of Other Official		39. Signature of Other Official	
40. Signature of Other Official		41. Signature of Other Official		42. Signature of Other Official	
43. Signature of Other Official		44. Signature of Other Official		45. Signature of Other Official	
46. Signature of Other Official		47. Signature of Other Official		48. Signature of Other Official	
49. Signature of Other Official		50. Signature of Other Official		51. Signature of Other Official	
52. Signature of Other Official		53. Signature of Other Official		54. Signature of Other Official	
55. Signature of Other Official		56. Signature of Other Official		57. Signature of Other Official	
58. Signature of Other Official		59. Signature of Other Official		60. Signature of Other Official	
61. Signature of Other Official		62. Signature of Other Official		63. Signature of Other Official	
64. Signature of Other Official		65. Signature of Other Official		66. Signature of Other Official	
67. Signature of Other Official		68. Signature of Other Official		69. Signature of Other Official	
70. Signature of Other Official		71. Signature of Other Official		72. Signature of Other Official	
73. Signature of Other Official		74. Signature of Other Official		75. Signature of Other Official	
76. Signature of Other Official		77. Signature of Other Official		78. Signature of Other Official	
79. Signature of Other Official		80. Signature of Other Official		81. Signature of Other Official	
82. Signature of Other Official		83. Signature of Other Official		84. Signature of Other Official	
85. Signature of Other Official		86. Signature of Other Official		87. Signature of Other Official	
88. Signature of Other Official		89. Signature of Other Official		90. Signature of Other Official	
91. Signature of Other Official		92. Signature of Other Official		93. Signature of Other Official	
94. Signature of Other Official		95. Signature of Other Official		96. Signature of Other Official	
97. Signature of Other Official		98. Signature of Other Official		99. Signature of Other Official	
100. Signature of Other Official		101. Signature of Other Official		102. Signature of Other Official	



6185 CERTIFICATE OF DEATH

Reg. Dist. No. 302 06183

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				d. STREET ADDRESS <b>1110 Fry Ave.</b>			
3. NAME OF DECEASED (Type or print) <b>ELIZABETH RITTER GRANTLAND</b>				4. DATE OF DEATH <b>May 26 19 58</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 25, 1911</b>	9. AGE (In years last birthday) <b>46</b> yrs.	IF UNDER 1 YEAR Months <b>10</b> Days <b>1</b>	IF UNDER 24 HRS. Hours <b>1</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Wilmington, Del.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>William E. Ritter</b>				14. MOTHER'S MAIDEN NAME <b>Mary Taylor</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>221-09-0089</b>		17. INFORMANT <b>Mr. George P. Grantland</b> Address <b>Hagerstown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Congestion</b> DUE TO <b>410X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Mitral Stenosis</b> DUE TO <b>Rheumatic Heart Disease</b> (c) <b>30 yrs.</b>						INTERVAL BETWEEN ONSET AND DEATH <b>4 weeks</b> <b>25 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>8 Feb. 1957</b> to <b>26 May 1958</b> , that I last saw the deceased alive on <b>26 May 1958</b> , and that death occurred at <b>11:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1135 Pittman Ave. Hagerstown Md.</b> DATE SIGNED <b>27 May 58</b>							
ACTUAL SIGNATURE <b>Richard T. Binford</b>		PHYSICIAN'S NAME (Type) <b>Richard T. Binford</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/30/1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lombardy Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Wilmington, Delaware</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Suter-Houzer Funeral Home</b> <b>R. Franklin Houzer</b>				ADDRESS <b>Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 28 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>W. Deane</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







6186

## CERTIFICATE OF DEATH

06184

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <b>MARYLAND</b> c. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>			
c. LENGTH OF STAY IN 1b <b>2 WEEKS</b>				d. STREET ADDRESS <b>253 SOUTH MULBERRY STREET</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WASHINGTON COUNTY HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>FLORA MAE GRIFFITH</b>				4. DATE OF DEATH Month Day Year <b>MAY 9 1958 19</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>69</b> yrs.	
9. AGE (In years last birthday) <b>69</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>WASHINGTON COUNTY MD.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>JOHN LEWIS</b>				14. MOTHER'S MAIDEN NAME <b>MARTHA HOLMES</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>FLOYD W. GRIFFITH</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma uterus</b> DUE TO <b>with carcinomatosis of abdomen</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>None</b>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>none 19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>	
20f. (City or town) <b>-</b>				20g. (County) <b>-</b>		20h. (State) <b>-</b>	
21. I certify that I attended the deceased from <b>Oct. 1947</b> to <b>May 9 1958</b> , that I last saw the deceased alive on <b>May 9 1958</b> , and that death occurred at <b>11:34 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>S. Robert Wells</b> M.D.				ADDRESS (Street, city or town, state) <b>115 N. Potomac Street</b>			
DATE SIGNED <b>9-12-58</b>							
PHYSICIAN'S NAME (Type) <b>S. Robert Wells, M.D.</b>				Hagerstown, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>BURIAL</b>		<b>MAY 13 1958</b>		<b>ROSE HILL CEMETERY</b>		<b>HAGERSTOWN MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>East Laurel Home</b>				ADDRESS <b>Boonsboro Md</b>		24a. REC'D BY REGISTRAR <b>MAY 19 '58</b>	
						24b. REGISTRAR'S SIGNATURE <b>Albert...</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

TAHIN BOGIN

DO NOT WRITE IN THESE SPACES

Name of Deceased		Date of Birth		Sex	
Race		Color		Marital Status	
Place of Birth		Usual Residence		Occupation	
Cause of Death		Immediate Cause		Underlying Cause	
Manner of Death		Date of Death		Time of Death	
Place of Death		Physician's Signature		Physician's License No.	
Medical Examiner's Signature		Medical Examiner's License No.		County	
City		State		Zip	

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE STATE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND, AND A COPY IS TO BE FURNISHED TO THE LOCAL HEALTH DEPARTMENT, CITY OR COUNTY, WHERE THE DECEASED RESIDES OR WAS LAST SEEN ALIVE.



## 6187 CERTIFICATE OF DEATH

Reg. Dist. No. 02

06185

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>LUCY</u> Last <u>HALL</u>		4. DATE OF DEATH Month <u>May</u> Day <u>2</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 9 1883</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>19</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stitcher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Southern Shoe Co</u>	
11. BIRTHPLACE (State or foreign country) <u>Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Downs</u>		14. MOTHER'S MAIDEN NAME <u>Sarah C. Shaver</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-09-0459</u>	
17. INFORMANT <u>Glenn V. Hall</u>		Address <u>1106 Oak Hill Ave Hagerstown Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>180x Carcinoma of kidney, left, with wide-spread metastases.</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>Months.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive Cardiovascular Disease.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Jan. 4, 1958</u> , to <u>May 2, 1958</u> , that I last saw the deceased alive on <u>May 2, 1958</u> , and that death occurred at <u>5:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R.A. Bell</u>		ADDRESS (Street, city or town, state) <u>119 N. Potomac Street, 5-3-58</u>	
PHYSICIAN'S NAME (Type) <u>R.A. Bell, M.D.</u>		DATE SIGNED <u>Hagerstown, Maryland.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/4/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		24a. REC'D BY REGISTRAR <u>MAY 6 '58</u>	
ADDRESS <u>Hagerstown Md.</u>		24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 17

FILED  
MAY 11 1961  
BALTIMORE

NAME OF DECEASED		DATE OF BIRTH		PLACE OF BIRTH	
SEX		RACE		EDUCATION	
MARRIAGE		OCCUPATION		HABIT OF SMOKING	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		IMMEDIATE CAUSE		UNDERLYING CAUSE	
DATE OF REPORT		REPORTED BY		SIGNATURE OF REPORTER	
DATE OF ENTRY		ENTRY BY		SIGNATURE OF ENTRY CLERK	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film G229 5-28-58 et

6235

## CERTIFICATE OF DEATH

Reg. Dist. No.

06186

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wash.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>		c. LENGTH OF STAY IN 1b <u>18 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Clearspring</u>		d. STREET ADDRESS <u>1 Route #1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Williamsport Sanitarium</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mr. Eugene J. Hamborszky</u>		4. DATE OF DEATH <u>May 20 1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 10, 1887</u>
9. AGE (In years lost birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PHYSICIAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hungary</u>	
11. BIRTHPLACE (State or foreign country) <u>Hungary</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Julius Hamborszky</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Toth</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>192-26-6025</u>	
17. INFORMANT <u>MRS. CLARA HAMBORSZKY</u>		Address <u>CLEARSPRING AFD #1</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>581.0</u> DUE TO <u>HEPATIC FAILURE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>PORTAL CIRRHOSIS</u> (c) <u>UNKNOWN</u>		INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>HYPERTENSIVE ARTERIOSCLEROTIC HEART DISEASE</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JAN 9 1958</u> to <u>MAY 20 1958</u> , that I last saw the deceased alive on <u>MAY 19 1958</u> , and that death occurred at <u>7 PM</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <u>Archie Robert Cohen</u> M.D.			
PHYSICIAN'S NAME (Type) <u>ARCHIE ROBERT COHEN, M.D.</u>		<u>CLEAR SPRING, MD 5/22/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		22b. DATE THEREOF <u>5/23/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>WASHINGTON D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. ...</u>		ADDRESS <u>Baltimore, Maryland</u>	
24a. REC'D BY REGISTRAR <u>MAY 26 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. ...</u>	



CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF DEATH	
ROBERT C. HARRIS		M		38		JULY 12, 1932	
PLACE OF DEATH		CITY		COUNTY		STATE	
BALTIMORE		BALTIMORE		BALTIMORE		MARYLAND	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION	
HEART FAILURE		NATURAL		LABORER		HIGH SCHOOL	
DATE OF BIRTH		PLACE OF BIRTH		DATE OF DEATH		TIME OF DEATH	
JULY 12, 1932		BALTIMORE, MD		JULY 12, 1932		10:30 AM	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED	
[Signature]		[Signature]		[Signature]		[Signature]	
DATE		TIME		PLACE		STATE	
JULY 12, 1932		10:30 AM		BALTIMORE		MARYLAND	





## 6188 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		d. STREET ADDRESS <b>127 Randolph Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>EARL</b> Middle <b>EDWARD</b> Last <b>HANN</b>		4. DATE OF DEATH Month <b>May</b> Day <b>9</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 17, 1907</b>
9. AGE (In years last birthday) <b>50</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>9</b> Days <b>9</b> Hours <b>1958</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Broom Maker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Manufacturing</b>	
11. BIRTHPLACE (State or foreign country) <b>Hanover, Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Thomas Hann</b>		14. MOTHER'S MAIDEN NAME <b>Annie May Garrett</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>214-09-767</b>	
17. INFORMANT <b>R.J. Hann</b>		Address <b>110 S. Potomac St. Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Rheumatic Valvular heart disease</b> <b>414X</b> DUE TO <b>Acute Lobar pneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>490X</b> <b>None</b>		INTERVAL BETWEEN ONSET AND DEATH <b>30 hrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>None</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>None</b>		20f. (City or town) (County) (State) <b>- - -</b>	
21. I certify that I attended the deceased from <b>June 14</b> , 19 <b>57</b> , to <b>May 9</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>May 3</b> , 19 <b>58</b> , and that death occurred at <b>6:30 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>S.R. Wells</b>		ADDRESS (Street, city or town, state) <b>115 N. Potomac Street</b>	
DATE SIGNED <b>5-10-58</b>			
PHYSICIAN'S NAME (Type) <b>S.R. Wells M.D.</b>		<b>115 N. Potomac St. Hagerstown, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5/12/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Rest Haven Funeral Chapel Inc.</b>		ADDRESS <b>1601 Penna. Ave. Hagerstown, Md.</b>	
24a. REC'D BY REGISTRAR <b>DATE MAY 12 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Alb. Leach</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES EARL RAY		35		M		W		1928		MEMPHIS		TENNESSEE		UNITED STATES		UNITED STATES	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH	
APRIL 4, 1968		MEMPHIS		MEMPHIS		TENNESSEE		UNITED STATES		APRIL 4, 1968		MEMPHIS		MEMPHIS		TENNESSEE	
TIME OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		ORGAN OR SYSTEM		DISEASE OR INJURY		ORGAN OR SYSTEM		DISEASE OR INJURY		ORGAN OR SYSTEM	
10:00 PM		HEART DISEASE		SUICIDE		CORONARY ARTERY DISEASE		HEART		CORONARY ARTERY DISEASE		HEART		CORONARY ARTERY DISEASE		HEART	
PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH	
MEMPHIS		MEMPHIS		TENNESSEE		UNITED STATES		APRIL 4, 1968		MEMPHIS		MEMPHIS		TENNESSEE		UNITED STATES	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH	
APRIL 4, 1968		MEMPHIS		MEMPHIS		TENNESSEE		UNITED STATES		APRIL 4, 1968		MEMPHIS		MEMPHIS		TENNESSEE	
TIME OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		ORGAN OR SYSTEM		DISEASE OR INJURY		ORGAN OR SYSTEM		DISEASE OR INJURY		ORGAN OR SYSTEM	
10:00 PM		HEART DISEASE		SUICIDE		CORONARY ARTERY DISEASE		HEART		CORONARY ARTERY DISEASE		HEART		CORONARY ARTERY DISEASE		HEART	
PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH	
MEMPHIS		MEMPHIS		TENNESSEE		UNITED STATES		APRIL 4, 1968		MEMPHIS		MEMPHIS		TENNESSEE		UNITED STATES	

THIS IS A COPY OF THE ORIGINAL

RECEIVED BY THE STATE DEPARTMENT OF HEALTH  
BALTIMORE, MARYLAND  
APRIL 10, 1968



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6189

## CERTIFICATE OF DEATH

06188

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland.</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>1 Week</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Rural 1 Hancock Md.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				d. STREET ADDRESS <b>Rural 1 Hancock Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Sarah</b> Middle <b>Elizabeth</b> Last <b>Hoss</b>				4. DATE OF DEATH Month <b>5</b> Day <b>16</b> Year <b>19 58</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6.4.1868</b>	9. AGE (In years last birthday) <b>89</b> yrs.	IF UNDER 1 YEAR Months <b>11</b> Days <b>12</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Fulton County Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Hendershot</b>				14. MOTHER'S MAIDEN NAME <b>Elixabeth Richards</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Lester C Divel Hancock Md.</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic C-V disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Arteriosclerosis</b> DUE TO (c) <b>Fracture of left hip</b>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>904.0</b> <b>Central Arteriosclerosis</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell in home &amp; fractured L hip</b>					
20c. TIME OF INJURY Month, Day, Year Hour, a. m. <b>May 8 1958</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Hancock Wash Md</b>	
21. I certify that I attended the deceased from <b>May 8, 1958</b> , to <b>May 16, 1958</b> , that I last saw the deceased alive on <b>May 16, 1958</b> , and that death occurred at <b>4 A. M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>John A. Moran</b> M.D.				ADDRESS (Street, city or town, state) <b>215 W Washington St</b>			
PHYSICIAN'S NAME (Type) <b>JOHN A. MORAN</b>				DATE SIGNED <b>5/17/58</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5.18.58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Pleasant Grove Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Fulton County Penna.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard J Stone</b>				ADDRESS <b>Hancock Md</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 27 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>W. H. Beach</b>			







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

06189

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BENEVOLE RURAL</b> c. LENGTH OF STAY IN 1b <b>35 YEARS</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>BOONSBORO MD. ROUTE 1</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BENEVOLE RURAL</b> d. STREET ADDRESS <b>BOONSBORO MD. ROUTE 1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>LINLEY HUNTER HINES</b>		4. DATE OF DEATH Month Day Year <b>MAY 9 1958 19</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DECEMBER 27 1875</b>
9. AGE (In years last birthday) <b>82 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN FARM</b>	
11. BIRTHPLACE (State or foreign country) <b>ROMNEY WEST VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>GEORGE HINES</b>		14. MOTHER'S MAIDEN NAME <b>REBECCA EVERETT</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>CLYDE G. HINES BOONSBORO MD. R. 1</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0 Anteriosclerotic Heart Disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>asthmatic Bronchitis, Emphysema</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept 11, 1957</b> , to <b>4/11/58</b> , 19____, that I last saw the deceased alive on <b>4/11/58</b> , 19____, and that death occurred at <b>5:20 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Robert V. H. Campbell</b> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <b>145 W Washington St Hagenstown MC</b>	
PHYSICIAN'S NAME (Type) <b>Robert V. H. Campbell</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>MAY 12 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>BENEVOLE CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>BENEVOLE WASH. CO. MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>East Funeral Home</b>		24a. REC'D BY REGISTRAR <b>Boonsboro Md</b>	
24b. REGISTRAR'S SIGNATURE <b>Alfred</b>		DATE <b>MAY 12 58</b>	



# CERTIFICATE OF DEATH

STATE OF NEW YORK

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6190

CERTIFICATE OF DEATH

Reg. Dist. No. 06190

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>913 Guilford Avenue</u>				d. STREET ADDRESS <u>1 913 Guilford Avenue</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Medora</u> Last <u>Hoch</u>		4. DATE OF DEATH Month <u>May</u> Day <u>7</u> Year <u>19 58</u>					
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 8, 1876</u>	9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months <u>6</u> Days <u>29</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Chewsville, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Isiah J. Beard</u>				14. MOTHER'S MAIDEN NAME <u>Sarah J. Mullen</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Austin O'Dell Hoch, Hagerstown, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>General Arterio Sclerosis</u> <u>151X also Carcinoma of Stomach</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 yr. 8 mo.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of Stomach.</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Hagerstown</u>		(County) (State)	
21. I certify that I attended the deceased from <u>May 1, 1958</u> to <u>May 7, 1958</u> , that I last saw the deceased alive on <u>May 1, 1958</u> , and that death occurred at <u>1041 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. A. Beachley</u>				DATE SIGNED <u>May 7/58</u>			
PHYSICIAN'S NAME (Type) <u>J. A. Beachley</u>				M.D. <u>Hagerstown, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5-10-1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Franklin Rouse</u>				24a. REC'D BY REGISTRAR <u>DATE MAY 13 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Archibald</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>JOHN J. SMITH</i>		2. SEX <i>MALE</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>1945</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>HOME</i>	
7. CITY OR TOWN <i>BALTIMORE</i>		8. COUNTY <i>JOHNS HOPKINS</i>		9. STATE <i>MARYLAND</i>	
10. OCCUPATION <i>CLERK</i>		11. CAUSE OF DEATH <i>HEART DISEASE</i>		12. MANNER OF DEATH <i>NATURAL</i>	
13. SIGNATURE OF PHYSICIAN <i>J. H. SMITH</i>		14. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		15. SIGNATURE OF WITNESSES <i>J. H. SMITH</i>	
16. SIGNATURE OF REGISTRAR <i>J. H. SMITH</i>		17. SIGNATURE OF CLERK <i>J. H. SMITH</i>		18. SIGNATURE OF JURY <i>J. H. SMITH</i>	
19. SIGNATURE OF JURY <i>J. H. SMITH</i>		20. SIGNATURE OF JURY <i>J. H. SMITH</i>		21. SIGNATURE OF JURY <i>J. H. SMITH</i>	
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1. NAME OF DECEASED  
2. SEX  
3. AGE  
4. DATE OF DEATH  
5. TIME OF DEATH  
6. PLACE OF DEATH  
7. CITY OR TOWN  
8. COUNTY  
9. STATE  
10. OCCUPATION  
11. CAUSE OF DEATH  
12. MANNER OF DEATH  
13. SIGNATURE OF PHYSICIAN  
14. SIGNATURE OF DECEASED  
15. SIGNATURE OF WITNESSES  
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102. SIGNATURE OF JURY



Reg. Dist. No. 06191

81

VS A1S (4)  
ISM 10/57







06192

## 6192 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		d. STREET ADDRESS <b>/ 1909 Gay Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>SPRIGG EVERS HOUSER</b>		4. DATE OF DEATH Month <b>May</b> Day <b>26</b> Year <b>19 58</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 6, 1875</b>	
9. AGE (In years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Samuel O. Houser</b>		14. MOTHER'S MAIDEN NAME <b>No Record</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-12-1032 A</b>	
17. INFORMANT <b>Mrs. Bettie J. Stoner</b>		Address <b>1909 Gay St.-Hagers.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute cerebral hemorrhage</b> DUE TO <b>Vascular hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic myocardial heart disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>None</b> p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f. (City or town) (County) (State) <b>- - -</b>	
21. I certify that I attended the deceased from <b>Oct.</b> , 19 <b>52</b> , to <b>May 26</b> , 19 <b>58</b> , that I lost saw the deceased olive on <b>May 25</b> , 19 <b>58</b> , and that death occurred at <b>6:25 A.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>115 N. Potomac Street</b> DATE SIGNED <b>5-26-58</b> ACTUAL SIGNATURE <b>S. Robert Wells</b> M.D. PHYSICIAN'S NAME (Type) <b>S. Robert Wells, M.D.</b> <b>Hagerstown, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-28-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman-Hagerstown, Maryland</b>		24a. REC'D BY REGISTRAR <b>MAY 28 1958</b>	
24b. REGISTRAR'S SIGNATURE <b>W. J. ...</b>			

VS A15 (4)  
15M 10/57



# CERTIFICATE OF DEATH

STATE OF OHIO

MADE IN U.S.A.

<p>1. Name of Deceased: _____</p>		<p>2. Sex: _____</p>	
<p>3. Date of Birth: _____</p>		<p>4. Place of Birth: _____</p>	
<p>5. Date of Death: _____</p>		<p>6. Place of Death: _____</p>	
<p>7. Cause of Death: _____</p>		<p>8. Manner of Death: _____</p>	
<p>9. Signature of Physician: _____</p>		<p>10. Signature of Registrar: _____</p>	
<p>11. Signature of Coroner: _____</p>		<p>12. Signature of Medical Examiner: _____</p>	
<p>13. Signature of Burial Director: _____</p>		<p>14. Signature of Funeral Home: _____</p>	
<p>15. Signature of Cemetery: _____</p>		<p>16. Signature of Interment: _____</p>	
<p>17. Signature of Burial: _____</p>		<p>18. Signature of Burial: _____</p>	
<p>19. Signature of Burial: _____</p>		<p>20. Signature of Burial: _____</p>	
<p>21. Signature of Burial: _____</p>		<p>22. Signature of Burial: _____</p>	
<p>23. Signature of Burial: _____</p>		<p>24. Signature of Burial: _____</p>	
<p>25. Signature of Burial: _____</p>		<p>26. Signature of Burial: _____</p>	
<p>27. Signature of Burial: _____</p>		<p>28. Signature of Burial: _____</p>	
<p>29. Signature of Burial: _____</p>		<p>30. Signature of Burial: _____</p>	
<p>31. Signature of Burial: _____</p>		<p>32. Signature of Burial: _____</p>	
<p>33. Signature of Burial: _____</p>		<p>34. Signature of Burial: _____</p>	
<p>35. Signature of Burial: _____</p>		<p>36. Signature of Burial: _____</p>	
<p>37. Signature of Burial: _____</p>		<p>38. Signature of Burial: _____</p>	
<p>39. Signature of Burial: _____</p>		<p>40. Signature of Burial: _____</p>	
<p>41. Signature of Burial: _____</p>		<p>42. Signature of Burial: _____</p>	
<p>43. Signature of Burial: _____</p>		<p>44. Signature of Burial: _____</p>	
<p>45. Signature of Burial: _____</p>		<p>46. Signature of Burial: _____</p>	
<p>47. Signature of Burial: _____</p>		<p>48. Signature of Burial: _____</p>	
<p>49. Signature of Burial: _____</p>		<p>50. Signature of Burial: _____</p>	
<p>51. Signature of Burial: _____</p>		<p>52. Signature of Burial: _____</p>	
<p>53. Signature of Burial: _____</p>		<p>54. Signature of Burial: _____</p>	
<p>55. Signature of Burial: _____</p>		<p>56. Signature of Burial: _____</p>	
<p>57. Signature of Burial: _____</p>		<p>58. Signature of Burial: _____</p>	
<p>59. Signature of Burial: _____</p>		<p>60. Signature of Burial: _____</p>	
<p>61. Signature of Burial: _____</p>		<p>62. Signature of Burial: _____</p>	
<p>63. Signature of Burial: _____</p>		<p>64. Signature of Burial: _____</p>	
<p>65. Signature of Burial: _____</p>		<p>66. Signature of Burial: _____</p>	
<p>67. Signature of Burial: _____</p>		<p>68. Signature of Burial: _____</p>	
<p>69. Signature of Burial: _____</p>		<p>70. Signature of Burial: _____</p>	
<p>71. Signature of Burial: _____</p>		<p>72. Signature of Burial: _____</p>	
<p>73. Signature of Burial: _____</p>		<p>74. Signature of Burial: _____</p>	
<p>75. Signature of Burial: _____</p>		<p>76. Signature of Burial: _____</p>	
<p>77. Signature of Burial: _____</p>		<p>78. Signature of Burial: _____</p>	
<p>79. Signature of Burial: _____</p>		<p>80. Signature of Burial: _____</p>	
<p>81. Signature of Burial: _____</p>		<p>82. Signature of Burial: _____</p>	
<p>83. Signature of Burial: _____</p>		<p>84. Signature of Burial: _____</p>	
<p>85. Signature of Burial: _____</p>		<p>86. Signature of Burial: _____</p>	
<p>87. Signature of Burial: _____</p>		<p>88. Signature of Burial: _____</p>	
<p>89. Signature of Burial: _____</p>		<p>90. Signature of Burial: _____</p>	
<p>91. Signature of Burial: _____</p>		<p>92. Signature of Burial: _____</p>	
<p>93. Signature of Burial: _____</p>		<p>94. Signature of Burial: _____</p>	
<p>95. Signature of Burial: _____</p>		<p>96. Signature of Burial: _____</p>	
<p>97. Signature of Burial: _____</p>		<p>98. Signature of Burial: _____</p>	
<p>99. Signature of Burial: _____</p>		<p>100. Signature of Burial: _____</p>	



## 6193 CERTIFICATE OF DEATH

06193

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN lb <b>5 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Williamsport</b>	
3. NAME OF DECEASED (Type or print) First <b>Jesse</b> Middle <b>Hampton</b> Last <b>Howell</b>		4. DATE OF DEATH Month <b>May</b> Day <b>20</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 13 1905</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labor</b>		10b. KIND OF BUSINESS, OR INDUSTRY <b>Cannery &amp; Dairy</b>	
11. BIRTHPLACE (State or foreign country) <b>Williamsport Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Lee H. Howell</b>		14. MOTHER'S MAIDEN NAME <b>Neva Goins</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>218 01 6573</b>	
17. INFORMANT <b>Mrs. June Artz</b>		Address <b>47 W. Salisbury St. Williamsport Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY THROMBOSIS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>1 Day</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <b>5/19/58</b> 19 to <b>5/20/58</b> 19, that I last saw the deceased alive on <b>5/20/58</b> 19, and that death occurred at <b>9:30 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Ralph Young</b>		ADDRESS (Street, city or town, state) <b>Williamsport Md.</b>	
PHYSICIAN'S NAME (Type) <b>Albert L. Steff</b>		DATE SIGNED <b>5/21/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>May 23-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Albert L. Steff</b>		ADDRESS <b>Williamsport, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>MAY 26 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. E. Leach</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

MASSACHUSETTS  
DEPARTMENT OF HEALTH  
BOSTON

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH	
JAMES J. BRIDGES		45		M		W		1914	
RESIDENCE		CITY		COUNTY		STATE		DATE OF BIRTH	
100 N. ST.		BOSTON		SUFFOLK		MASS.		1869	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		DATE OF INTERMENT	
LABORER		HEART DISEASE		NATURAL		HOME		1914	
EDUCATION		RELIGION		MARRIAGE		SINGLE		DATE OF MARRIAGE	
HIGH SCHOOL		CATHOLIC		YES		NO		1900	
SIGNED		WITNESSED		CERTIFIED		FILED		DATE	
J. J. BRIDGES		J. J. BRIDGES		J. J. BRIDGES		J. J. BRIDGES		1914	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6194 CERTIFICATE OF DEATH

Reg. Dist. No. **06194**

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Washington</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Penna</u> b. COUNTY <u>Franklin</u>											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>3 1/2 mos</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Route # 3 75x-3</u>									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Jackson Convalescent Home</u>				d. STREET ADDRESS <u>Waynesboro</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Cyrus</u> Middle <u>Hykes</u> Last <u>Hykes</u>				<b>DATE OF DEATH</b> Month <u>May</u> Day <u>11</u> Year <u>1958</u>											
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>May 22, 1879</u>									
<b>9. AGE</b> (In years, lost birthday) <u>78</u> yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <th>Months</th> <th>Days</th> <th>Hours</th> <th>Min.</th> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.	<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Farming</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Farmer</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Franklin Co. Penna</u>	
IF UNDER 1 YEAR		IF UNDER 24 HRS.													
Months	Days	Hours	Min.												
<b>13. FATHER'S NAME</b> <u>Elias Hykes</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Christina Brechbeil</u>											
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>104-30-7697</u>		<b>17. INFORMANT</b> <u>Mr. Edgar Hykes, Waynesboro, Pa</u>											
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>Coronary thromboses</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cancer of lung</u>															
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)											
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. p. m. _____ 19 _____				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)									
<b>20f. (City or town)</b> _____		<b>(County)</b> _____		<b>(State)</b> _____		<b>21. I certify that I attended the deceased from</b> <u>Jan</u> , 1958, to <u>May</u> , 1958, that I last saw the deceased alive on _____, 1958, and that death occurred at _____ M, from the causes and on the date stated above.									
<b>ACTUAL SIGNATURE</b> <u>Howard N. Weeks</u> M.D. <u>1364 Potomac</u>				<b>DATE SIGNED</b> <u>5/11/58</u>											
<b>PHYSICIAN'S NAME</b> (Type) <u>HOWARD N. WEEKS</u>				<u>Hagerstown, Md</u>											
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>5/14/1958</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Cedar Hill Cemetery</u>		<b>22d. LOCATION</b> (City, town, or county) <u>Greencastle Franklin Co. Penna</u>									
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Samuel M. Zimmerman, Greencastle, Pa</u>				<b>24a. REC'D BY REGISTRAR</b> <u>W. H. Beach</u>		<b>24b. REGISTRAR'S SIGNATURE</b>									
<b>DATE</b> <u>MAY 13 '58</u>															







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6195

## CERTIFICATE OF DEATH

Reg. Dist. No.

06195

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	c. LENGTH OF STAY IN 1b <b>40 yrs.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>121 W. Antietam St.</b>		d. STREET ADDRESS <b>121 W. Antietam St.</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>NORA</b> Middle <b>EDITH</b> Last <b>JAMES</b>		4. DATE OF DEATH Month <b>May</b> Day <b>3</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 15, 1882</b>
9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	11. BIRTHPLACE (State or foreign country) <b>Waynesboro, Penna.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Jacob Lizer</b>		14. MOTHER'S MAIDEN NAME <b>Edith McGinzev</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Jos. M. Hoffman</b> Address <b>Box 161 Smithsburg, Md.</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>1 Day</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>5/2/58</b> to <b>5/3/58</b> , that I last saw the deceased alive on <b>5/3/58</b> , and that death occurred at <b>9:47</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Ralph F. Young 9 M.D. Williamsport, Md. 5/6/58</b> <b>Ralph F. Young 9 101 E. Potomac St. Williamsport, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/6/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>
22d. LOCATION (City, town, or county) <b>Hagerstown</b>		(State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Rest Haven Funeral Chapel Inc.</b>		24a. REC'D BY REGISTRAR <b>MAY 7 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Wm. C. Horst - Urban.</b>



CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, possibly "John Doe"]		SEX [Faint text, possibly "Male"]		AGE [Faint text, possibly "45"]	
DATE OF DEATH [Faint text, possibly "Jan 15, 1950"]		TIME OF DEATH [Faint text, possibly "10:30 AM"]		PLACE OF DEATH [Faint text, possibly "Home"]	
CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		MANNER OF DEATH [Faint text, possibly "Natural"]		PLACE OF BIRTH [Faint text, possibly "Maryland"]	
OCCUPATION [Faint text, possibly "Teacher"]		MARITAL STATUS [Faint text, possibly "Married"]		EDUCATION [Faint text, possibly "High School"]	
PREVIOUS ILLNESS [Faint text, possibly "None"]		MEDICAL HISTORY [Faint text, possibly "Hypertension"]		SURVIVAL OF SURVIVORS [Faint text, possibly "Wife and 2 children"]	
SIGNATURE OF PHYSICIAN [Faint signature]		SIGNATURE OF REGISTRAR [Faint signature]		SIGNATURE OF WITNESSES [Faint signatures]	
DATE OF SIGNATURE [Faint text, possibly "Jan 15, 1950"]		DATE OF SIGNATURE [Faint text, possibly "Jan 15, 1950"]		DATE OF SIGNATURE [Faint text, possibly "Jan 15, 1950"]	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by signing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06196

Reg. Dist. No.

6237

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Funkstown</b> c. LENGTH OF STAY IN 1b <b>25 Yrs</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>2 East Baltimore St</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Funkstown</b> d. STREET ADDRESS <b>2 East Baltimore St</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last <b>EARL MCKINLEY KERSHNER</b>				4. DATE OF DEATH Month Day Year <b>May 4 1958 19</b>											
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 23 1897</b>		9. AGE (In years last birthday) <b>60 yrs.</b>		IF UNDER 1 YEAR Months Days <b>60</b>		IF UNDER 24 HRS. Hours Min. <b>19</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Store Keeper</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>				11. BIRTHPLACE (State or foreign country) <b>Hagerstown Wash. Co Md.</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>William Henry Kershner</b>						14. MOTHER'S MAIDEN NAME <b>Susan Myers</b>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>218-30-9584</b>				17. INFORMANT Address <b>Mrs Grace A. Kershner 2 E. Baltimore St Funkstown Md.</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) <b>420.1</b>												INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>															
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>None 19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f. (City or town) <b>-</b>		(County) <b>-</b>		(State) <b>-</b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .															
ACTUAL SIGNATURE <b>S. Robert Wells</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <b>May 5 '58</b>							
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>5/7/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>				22d. LOCATION (City, town, or county) (State) <b>Hagerstown Wash. Co Md.</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>						ADDRESS <b>Hagerstown Md.</b>				24a. REC'D BY REGISTRAR <b>MAY 8 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Alfred</b>			

MEDICAL CERTIFICATION







## CERTIFICATE OF DEATH

Items 8 &amp; 21, File # 6238 6/11/58 cas

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Williamsport</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Williamsport Sanitorium</b>		d. STREET ADDRESS <b>/ 1028 Mulberry Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>HEYSER</b> Last <b>LEMEN</b>		4. DATE OF DEATH Month <b>May</b> Day <b>31</b> , Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>24 Nov. 25, 1868</b>
9. AGE (In years last birthday) <b>89</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	11. BIRTHPLACE (State or foreign country) <b>Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Jacob F. Lemen</b>		14. MOTHER'S MAIDEN NAME <b>Sally Heyser</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-07-9685</b>	
17. INFORMANT <b>Robert C. Porter</b>		Address <b>1028 Mulberry Ave/</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1 Cardio Vascular Disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>2-3 hours</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>492X Age - Pneumonia April - 1958</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Apr 9</b> , 19 <b>58</b> , to <b>May 31</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>May 31</b> , 19 <b>58</b> , and that death occurred at <b>5:30</b> P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1457 1/2 Washington St Hagerstown Md</b> DATE SIGNED ACTUAL SIGNATURE <b>Dr Campbell</b> M.D. PHYSICIAN'S NAME (Type) <b>DR W. D. CAMPBELL</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-3-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>
22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>		24a. REC'D BY REGISTRAR <b>JUN 4 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Andrew K. Coffman</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

WILLIAM BROWN

WILLIAM BROWN

WILLIAM BROWN

WILLIAM BROWN

WILLIAM BROWN

WILLIAM BROWN

WILLIAM BROWN

WILLIAM BROWN

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WILLIAM BROWN

WILLIAM BROWN

WILLIAM BROWN



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6196 CERTIFICATE OF DEATH

06198

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Washington</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			c. LENGTH OF STAY IN 1b <u>2 Days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hancock</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				d. STREET ADDRESS <u>22 Taliaferro St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Raymond</u> Middle <u>Arthur</u> Last <u>Mann</u>				<b>4. DATE OF DEATH</b> Month <u>5.</u> Day <u>30</u> Year <u>19 58</u>			
<b>5. SEX</b> <u>M</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>1.11.1909</u>		<b>9. AGE</b> (In years last birthday) <u>49</u> yrs.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Labor</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Carpenter</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Fulton County Penna.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Joseph Mann</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Jennie Bishop</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>219-20-1585</u>		<b>17. INFORMANT</b> Address <u>Mrs Lucy M Mann Hancock Md.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rheumatic heart disease &amp; valvulitis, inactive</u> <u>414X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic bronchitis</u>						<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Hour _____ a. m. _____ p. m.	Month, _____ Day, _____ Year <u>19</u>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify</b> that I attended the deceased from <u>May 28</u> , 19 <u>58</u> , to <u>May 30</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>May 30</u> , 19 <u>58</u> , and that death occurred at <u>11 A.</u> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>170 W. Washington St Hagerstown Md.</u> DATE SIGNED _____ <b>ACTUAL SIGNATURE</b> <u>R. L. Stauffer</u> M.D. <b>PHYSICIAN'S NAME (Type)</b> <u>Hagerstown Md.</u>							
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>	<b>22b. DATE THEREOF</b> <u>6.2.58</u>	<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Mt. Olivet Comotory</u>		<b>22d. LOCATION</b> (City, town, or county) (State) <u>Near Hancock Washington Md.</u>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> ADDRESS <u>Howard J. Stone Hancock Md</u>				<b>24a. REC'D BY REGISTRAR</b> DATE <u>JUN 6 '58</u>	<b>24b. REGISTRAR'S SIGNATURE</b> <u>W. Leach</u>		















6197

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
c. LENGTH OF STAY IN 1b <u>19 days</u>				d. STREET ADDRESS <u>3829 White Ave</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Western Md State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>WARREN</u> Middle <u>L.</u> Last <u>McCall</u>				4. DATE OF DEATH Month <u>MAY</u> Day <u>4</u> Year <u>1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 17 1904</u>	9. AGE (In years last birthday) <u>54</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RAILROAD</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>UNITED STATES</u>	
13. FATHER'S NAME <u>WARREN McCall Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Sally Wash</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONP</u>		17. INFORMANT Address <u>Mrs. Emma McCall - Baltimore, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>440X PULMONARY CONGESTION AND EDEMA</u> DUE TO (b) <u>HYPERTENSIVE HEART DISEASE</u> DUE TO (c) <u>BENIGN HYPERTENSION WITH MALIGNANT EXACERBATION</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>3 years</u> <u>7 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>CORONARY ATHEROSCLEROSIS</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>April 15</u> , 19 <u>58</u> , to <u>MAY 4</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>MAY 3</u> , 19 <u>58</u> , and that death occurred at <u>1:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1500 PENNSYLVANIA AVE</u> DATE SIGNED <u>Wm. J. Zickner &amp; Sons, Inc.</u>							
ACTUAL SIGNATURE <u>Evaristo R. Lardizabal</u> M.D.				PHYSICIAN'S NAME (Type) <u>EVARISTO R. LARDIZABAL</u> <u>HAGERSTOWN, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-7-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem. Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Zickner &amp; Sons, Inc.</u> ADDRESS <u>Baltimore Md.</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 6 1958</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. J. Zickner</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 72 hours after death. Page 1 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







6198

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington Co. Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Janice</b> Middle <b>I.</b> Last <b>Meadows</b>		4. DATE OF DEATH Month <b>May</b> Day <b>8</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) <b>56</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House duties</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Dont Know</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <b>Elmer M. Meadows</b>		Address <b>949 Linwood Road</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral arteriosclerosis</b> DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH <b>7 weeks</b> <b>2-3 yrs +</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE. CONDITION GIVEN IN PART I (a) <b>Left hemiplegia; arteriosclerotic heart disease</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>22 Mar, 1958</b> to <b>8 May, 1958</b> , that I last saw the deceased alive on <b>8 May, 1958</b> , and that death occurred at <b>4:15 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Richard T. Binford</b> <b>11 May 58</b>			
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) <b>RICHARD T. BINFORD, M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/11/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rosedale Cemetary</b>		22d. LOCATION (City, town, or county) (State) <b>Martinsburg W. Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard K. Brown</b>		ADDRESS <b>Martinsburg W. Va.</b>	
24a. REC'D BY REGISTRAR <b>MAY 14 58</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Smith</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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6199

## CERTIFICATE OF DEATH

06202

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>55 YRS.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>GARDNER MEM. CONV. HOSP.</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 HAGERSTOWN</b>	
f. STREET ADDRESS <b>1231 S. LOCUST ST.</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>WILLIAM</b> First <b>RAYMOND</b> Middle <b>MEASE</b> Last		4. DATE OF DEATH <b>MAY</b> Month <b>1</b> Day <b>19</b> Year <b>58</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/9/1886</b>
9. AGE (In years lost birthday) <b>7</b> yrs.		IF UNDER 1 YEAR Months <b>7</b> Days <b>7</b>	IF UNDER 24 HRS. Hours <b>7</b> Min. <b>7</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED FREIGHT CONDUCTOR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RAIL ROAD</b>	
11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>PRUTENTA MEASE</b>		14. MOTHER'S MAIDEN NAME <b>MARY ELLEN SMITH</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>719-05-5303</b>	
17. INFORMANT <b>MRS. LEAH F. MEASE</b> Address <b>HAGERSTOWN MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage into Bladder</b> DUE TO <b>177x</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma prostate</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>5 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>April 28, 1954</b> , to <b>Mar 1, 1958</b> , that I last saw the deceased alive on <b>Mar 1, 1958</b> , and that death occurred at <b>2:45 P.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>145 W Washington</b> DATE SIGNED <b>5/2/58</b>			
ACTUAL SIGNATURE <b>Robert V. H. Campbell</b> M.D.		PHYSICIAN'S NAME (Type) <b>Robert T. V. H. Campbell Hagerstown Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>5/3/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEM.</b>	22d. LOCATION (City, town, or county) (State) <b>HAGERSTOWN MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Normant</b> ADDRESS <b>Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 5 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Alfred...</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

STATE OF NEW YORK - DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>		4. RACE <i>White</i>	
5. DATE OF DEATH <i>Jan 15 1925</i>		6. TIME OF DEATH <i>10:30 AM</i>		7. PLACE OF DEATH <i>Home</i>		8. CAUSE OF DEATH <i>Heart Disease</i>	
9. DISEASE OR INJURY <i>Myocardial Infarction</i>		10. PRESENTING SYMPTOMS <i>Chest pain, shortness of breath</i>		11. MEDICAL HISTORY <i>None</i>		12. OCCUPATION <i>Teacher</i>	
13. MARITAL STATUS <i>Married</i>		14. BIRTH DATE <i>Jan 15 1880</i>		15. BIRTH PLACE <i>New York City</i>		16. EDUCATION <i>High School</i>	
17. RELIGION <i>Protestant</i>		18. COLOR <i>White</i>		19. HEIGHT <i>5' 8"</i>		20. WEIGHT <i>160 lbs</i>	
21. SIGNATURE OF DECEASED <i>John Doe</i>		22. SIGNATURE OF WITNESS <i>John Smith</i>		23. SIGNATURE OF DECEASED <i>John Doe</i>		24. SIGNATURE OF WITNESS <i>John Smith</i>	
25. SIGNATURE OF DECEASED <i>John Doe</i>		26. SIGNATURE OF WITNESS <i>John Smith</i>		27. SIGNATURE OF DECEASED <i>John Doe</i>		28. SIGNATURE OF WITNESS <i>John Smith</i>	
29. SIGNATURE OF DECEASED <i>John Doe</i>		30. SIGNATURE OF WITNESS <i>John Smith</i>		31. SIGNATURE OF DECEASED <i>John Doe</i>		32. SIGNATURE OF WITNESS <i>John Smith</i>	
33. SIGNATURE OF DECEASED <i>John Doe</i>		34. SIGNATURE OF WITNESS <i>John Smith</i>		35. SIGNATURE OF DECEASED <i>John Doe</i>		36. SIGNATURE OF WITNESS <i>John Smith</i>	
37. SIGNATURE OF DECEASED <i>John Doe</i>		38. SIGNATURE OF WITNESS <i>John Smith</i>		39. SIGNATURE OF DECEASED <i>John Doe</i>		40. SIGNATURE OF WITNESS <i>John Smith</i>	
41. SIGNATURE OF DECEASED <i>John Doe</i>		42. SIGNATURE OF WITNESS <i>John Smith</i>		43. SIGNATURE OF DECEASED <i>John Doe</i>		44. SIGNATURE OF WITNESS <i>John Smith</i>	
45. SIGNATURE OF DECEASED <i>John Doe</i>		46. SIGNATURE OF WITNESS <i>John Smith</i>		47. SIGNATURE OF DECEASED <i>John Doe</i>		48. SIGNATURE OF WITNESS <i>John Smith</i>	
49. SIGNATURE OF DECEASED <i>John Doe</i>		50. SIGNATURE OF WITNESS <i>John Smith</i>		51. SIGNATURE OF DECEASED <i>John Doe</i>		52. SIGNATURE OF WITNESS <i>John Smith</i>	
53. SIGNATURE OF DECEASED <i>John Doe</i>		54. SIGNATURE OF WITNESS <i>John Smith</i>		55. SIGNATURE OF DECEASED <i>John Doe</i>		56. SIGNATURE OF WITNESS <i>John Smith</i>	
57. SIGNATURE OF DECEASED <i>John Doe</i>		58. SIGNATURE OF WITNESS <i>John Smith</i>		59. SIGNATURE OF DECEASED <i>John Doe</i>		60. SIGNATURE OF WITNESS <i>John Smith</i>	
61. SIGNATURE OF DECEASED <i>John Doe</i>		62. SIGNATURE OF WITNESS <i>John Smith</i>		63. SIGNATURE OF DECEASED <i>John Doe</i>		64. SIGNATURE OF WITNESS <i>John Smith</i>	
65. SIGNATURE OF DECEASED <i>John Doe</i>		66. SIGNATURE OF WITNESS <i>John Smith</i>		67. SIGNATURE OF DECEASED <i>John Doe</i>		68. SIGNATURE OF WITNESS <i>John Smith</i>	
69. SIGNATURE OF DECEASED <i>John Doe</i>		70. SIGNATURE OF WITNESS <i>John Smith</i>		71. SIGNATURE OF DECEASED <i>John Doe</i>		72. SIGNATURE OF WITNESS <i>John Smith</i>	
73. SIGNATURE OF DECEASED <i>John Doe</i>		74. SIGNATURE OF WITNESS <i>John Smith</i>		75. SIGNATURE OF DECEASED <i>John Doe</i>		76. SIGNATURE OF WITNESS <i>John Smith</i>	
77. SIGNATURE OF DECEASED <i>John Doe</i>		78. SIGNATURE OF WITNESS <i>John Smith</i>		79. SIGNATURE OF DECEASED <i>John Doe</i>		80. SIGNATURE OF WITNESS <i>John Smith</i>	
81. SIGNATURE OF DECEASED <i>John Doe</i>		82. SIGNATURE OF WITNESS <i>John Smith</i>		83. SIGNATURE OF DECEASED <i>John Doe</i>		84. SIGNATURE OF WITNESS <i>John Smith</i>	
85. SIGNATURE OF DECEASED <i>John Doe</i>		86. SIGNATURE OF WITNESS <i>John Smith</i>		87. SIGNATURE OF DECEASED <i>John Doe</i>		88. SIGNATURE OF WITNESS <i>John Smith</i>	
89. SIGNATURE OF DECEASED <i>John Doe</i>		90. SIGNATURE OF WITNESS <i>John Smith</i>		91. SIGNATURE OF DECEASED <i>John Doe</i>		92. SIGNATURE OF WITNESS <i>John Smith</i>	
93. SIGNATURE OF DECEASED <i>John Doe</i>		94. SIGNATURE OF WITNESS <i>John Smith</i>		95. SIGNATURE OF DECEASED <i>John Doe</i>		96. SIGNATURE OF WITNESS <i>John Smith</i>	
97. SIGNATURE OF DECEASED <i>John Doe</i>		98. SIGNATURE OF WITNESS <i>John Smith</i>		99. SIGNATURE OF DECEASED <i>John Doe</i>		100. SIGNATURE OF WITNESS <i>John Smith</i>	



6200

CERTIFICATE OF DEATH

Reg. Dist. No. 06203

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 HAGERSTOWN</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>WASHINGTON COUNTY HOSPITAL</u>		d. STREET ADDRESS <u>1614 W. WASHINGTON ST.</u>	
3. NAME OF DECEASED (Type or print) First <u>JOSEPH</u> Middle <u>CLEVELAND</u> Last <u>MILLER</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>18</u> Year <u>19 58</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/13/1885</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NIGHT WATCHMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DEPT. STORE</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOSEPH MILLER</u>		14. MOTHER'S MAIDEN NAME <u>MARTHA SPITZNOGLE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>214-09-2884</u>	
17. INFORMANT <u>MRS. BESSIE MILLER</u>		Address <u>HAGERSTOWN MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis - gen</u> <u>260x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>seal Arteriosclerosis</u> DUE TO (c) <u>Diabetes Mellitus</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u> <u>10 yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Benign Prostate Hypertrophy</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. _____ p. m. _____ Month, Day, Year _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>Feb 1</u> , 19 <u>58</u> , to <u>May 18</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>5/17/58</u> , 19 <u>58</u> , and that death occurred at <u>2:00 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Edward W. Ditto</u> M.D. <u>217 W. Washington Street</u> <u>5/19/58</u> PHYSICIAN'S NAME (Type) <u>Edward W. Ditto III, M.D.</u> <u>Hagerstown, Maryland</u>			
22a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>5/20/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ROSE HILL CEM.</u>	22d. LOCATION (City, town, or county) <u>HAGERSTOWN MD.</u> (State) _____
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. J. Norment</u> ADDRESS <u>Hagerstown, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE MAY 21 '58</u>	24b. REGISTRAR'S SIGNATURE <u>W. J. Norment</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 13



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06204

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	c. LENGTH OF STAY IN lb <b>Life</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>D.O.A.- Emergency Room- Hospital</b>		d. STREET ADDRESS <b>1 301 S.Potomac St.</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>RICKY</b> Middle <b>ROBERT</b> Last <b>MOFFITT</b>		4. DATE OF DEATH Month <b>May</b> Day <b>16</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 3, 1958</b>
9. AGE (In years last birthday) yrs. <b>2</b> Months <b>13</b> Days <b>13</b>		IF UNDER 1 YEAR Hours <b>13</b> Min. <b>13</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	
11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Kenneth R. Moffitt</b>		14. MOTHER'S MAIDEN NAME <b>Shirley Lee Hoffman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Kenneth R. Moffitt</b>		Address <b>Hagerstown, Md</b> <b>301 S.Potomac St.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia due to regurgitation and aspiration of vomitus</b> <b>784.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>784.1</b> DUE TO (c) <b>784.1</b> DUE TO			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>None</b> p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>	20f. (City or town) (County) (State) <b>- - -</b>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>S. Robert Wells</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>S.R. Wells M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 19, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Rest Haven Funeral Chapel Inc.</b>		24a. REC'D BY REGISTRAR <b>1601 Penna. Ave. Hagerstown, Md.</b>	
		24b. REGISTRAR'S SIGNATURE <b>MAY 20 '58</b>	







6240

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>		COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CLEVELANDVILLE RURAL</b>		c. LENGTH OF STAY IN 1b <b>LIFE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CLEVELANDVILLE RURAL</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>BOONSBORO MD. ROUTE 2</b>		d. STREET ADDRESS <b>BOONSBORO MD. ROUTE 2</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>AMANDA</b>		Middle <b>ELIZABETH</b>		Last <b>MORGAN</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>7</b> Year <b>1958</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 28 1886</b>		9. AGE (In years last birthday) <b>71</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>CLEVELANDVILLE WASH. CO. MD. U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>SAMUEL J. SMITH</b>		14. MOTHER'S MAIDEN NAME <b>MARY SMITH HUTZELL</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT Address <b>MRS. MARLIN WAGAMAN BOONSBORO MD. R.1</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1</b> DUE TO <b>Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic myocarditis with</b> DUE TO <b>3 days</b> (c) <b>edema of lungs</b>							INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 4, 1958</b> , to <b>May 7, 1958</b> , that I last saw the deceased alive on <b>May 7, 1958</b> , and that death occurred at <b>6:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Boonsboro</b> DATE SIGNED <b>md</b>							
ACTUAL SIGNATURE <b>G. W. LeVan</b>		M.D. <b>Boonsboro</b>					
PHYSICIAN'S NAME (Type) <b>G. W. LeVan</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>MAY 10 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>BOONSBORO CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>BOONSBORO WASH. CO. MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>East Funeral Home Boonsboro Md.</b>				ADDRESS		24a. REC'D BY REGISTRAR DATE <b>MAY 19 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur Smith</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# UNITED STATES DEPARTMENT OF HEALTH - BUREAU OF CENTRAL AIR DEATH

WILLIAM J. BROWN  
JAN 10 1922  
BUREAU OF  
CENTRAL AIR DEATH

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6202

## CERTIFICATE OF DEATH

06206

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Near Hagerstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SHARPSBURG</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>IN AMBULANCE ENROUTE TO HOSPITAL</b>		d. STREET ADDRESS <b>1 MAIN STREET</b>	
3. NAME OF DECEASED (Type or print) First <b>MARIE</b> Middle <b>ANNE</b> Last <b>MUNCH</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>4</b> Year <b>1958</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DEC. 7 1894</b>
9. AGE (In years last birthday) <b>63</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE KEEPER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>SAINT AMARIN FRANCE</b>		12. CITIZEN OF WHAT COUNTRY? <b>FRANCE</b>	
13. FATHER'S NAME <b>XAVIER STAHL</b>		14. MOTHER'S MAIDEN NAME <b>ANNE STAHL</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>RAYMOND F. MUNCH SHARPSBURG MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis -</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>arteriosclerosis with hypertension</b> DUE TO (c) <b>12 yrs.</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 hrs.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 2</b> , 19 <b>58</b> , to <b>May 4</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>May 4</b> , 19 <b>58</b> , and that death occurred at <b>3 P. M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Boronsboro</b> DATE SIGNED <b>5/5/58</b> ACTUAL SIGNATURE <b>G. W. LeVan</b> M.D. <b>Ind.</b> PHYSICIAN'S NAME (Type) <b>G. W. LeVan</b>			
22a. BURIAL, CREMATION, REMAINS (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>MAY 7 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>MOUNTAIN VIEW CEMETERY SHARPSBURG WASH. CO. MD.</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Best Funeral Home</b>		ADDRESS <b>Boronsboro Md.</b>	
24a. REC'D BY REGISTRAR <b>MAY 7 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Reese</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06207

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>D.O.A.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ROBIN</b> Middle <b>SUE</b> Last <b>MYERS</b>				4. DATE OF DEATH Month <b>May</b> Day <b>15</b> Year <b>19 58</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 17, 1957</b>	9. AGE (In years last birthday) <b>1</b> yrs.	IF UNDER 1 YEAR Months <b>1</b> Days <b>15</b>	IF UNDER 24 HRS. Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Infant</b>		11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George W. Myers</b>				14. MOTHER'S MAIDEN NAME <b>Shirley Ann Wishard</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Geo. W. Myers-752 W. Washington St.-Hag.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fractured Cervical Vertebra ( Closed )</b> 816X DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c) _____ DUE TO (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Passenger in auto that struck the rear of a City bus</b>					
20c. TIME OF INJURY Month, Day, Year <b>12:20 p.m. May 15 19 58</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway</b>		20f. (City or town) (County) (State) <b>Hagerstown Wash Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>S. Robert Wells</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-17-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt View Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Sharpsburg Wash. Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman-Hagerstown, Maryland</b>				24a. REC'D BY REGISTRAR <b>MAY 19 58</b>		24b. REGISTRAR'S SIGNATURE <b>W. J. Smith</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate using the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.







CERTIFICATE OF DEATH

06208

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1075 View St.</u>				d. STREET ADDRESS <u>1 1075 View St.</u>			
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>NICHOLSON</u> Last <u>NICHOLSON</u>				4. DATE OF DEATH Month <u>May</u> Day <u>19</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 20, 1889</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Artist</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Aircraft</u>		11. BIRTHPLACE (State or foreign country) <u>England</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>David Nicholson</u>				14. MOTHER'S MAIDEN NAME <u>Kate Robson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-12-9879</u>		17. INFORMANT <u>Mrs. John Nicholson</u> Address <u>1075 View St. Hagerstown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary atherosclerosis</u> DUE TO (c) <u>Hypertensive cardiovascular disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>10 min.</u> <u>Indefinite</u> <u>Indefinite</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral thrombosis with hemiplegia</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	
20f. (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>							
21. I certify that I attended the deceased from <u>Jan. 1958</u> , to <u>May 19 1958</u> , that I last saw the deceased alive on <u>April 7 1958</u> , and that death occurred at <u>2:10 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>148 West Washington St. Hagerstown, Maryland</u> DATE SIGNED <u>5/20/58</u> ACTUAL SIGNATURE <u>B. B. Kneisley</u> M.D. PHYSICIAN'S NAME (Type) <u>B. B. Kneisley, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/21/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Rest Haven Funeral Chapel Inc.</u>				ADDRESS <u>1601 Penna. Ave. Hagerstown, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 21 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Wm. C. Host</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH Jan 5, 1928		5. PLACE OF BIRTH Jackson, Mississippi	
6. OCCUPATION Attorney		7. MARITAL STATUS Single		8. COLOR White		9. RELIGION Methodist		10. EDUCATION High School	
11. DATE OF DEATH June 4, 1968		12. TIME OF DEATH 10:00 PM		13. PLACE OF DEATH Memphis, Tennessee		14. CAUSE OF DEATH Gunshot wound		15. MANNER OF DEATH Suicide	
16. SIGNATURE OF DECEASED (None)		17. SIGNATURE OF WITNESS JAMES EARL RAY		18. SIGNATURE OF PHYSICIAN JAMES EARL RAY		19. SIGNATURE OF CORONER JAMES EARL RAY		20. SIGNATURE OF JURY JAMES EARL RAY	
21. SIGNATURE OF DECEASED (None)		22. SIGNATURE OF WITNESS JAMES EARL RAY		23. SIGNATURE OF PHYSICIAN JAMES EARL RAY		24. SIGNATURE OF CORONER JAMES EARL RAY		25. SIGNATURE OF JURY JAMES EARL RAY	
26. SIGNATURE OF DECEASED (None)		27. SIGNATURE OF WITNESS JAMES EARL RAY		28. SIGNATURE OF PHYSICIAN JAMES EARL RAY		29. SIGNATURE OF CORONER JAMES EARL RAY		30. SIGNATURE OF JURY JAMES EARL RAY	
31. SIGNATURE OF DECEASED (None)		32. SIGNATURE OF WITNESS JAMES EARL RAY		33. SIGNATURE OF PHYSICIAN JAMES EARL RAY		34. SIGNATURE OF CORONER JAMES EARL RAY		35. SIGNATURE OF JURY JAMES EARL RAY	
36. SIGNATURE OF DECEASED (None)		37. SIGNATURE OF WITNESS JAMES EARL RAY		38. SIGNATURE OF PHYSICIAN JAMES EARL RAY		39. SIGNATURE OF CORONER JAMES EARL RAY		40. SIGNATURE OF JURY JAMES EARL RAY	
41. SIGNATURE OF DECEASED (None)		42. SIGNATURE OF WITNESS JAMES EARL RAY		43. SIGNATURE OF PHYSICIAN JAMES EARL RAY		44. SIGNATURE OF CORONER JAMES EARL RAY		45. SIGNATURE OF JURY JAMES EARL RAY	
46. SIGNATURE OF DECEASED (None)		47. SIGNATURE OF WITNESS JAMES EARL RAY		48. SIGNATURE OF PHYSICIAN JAMES EARL RAY		49. SIGNATURE OF CORONER JAMES EARL RAY		50. SIGNATURE OF JURY JAMES EARL RAY	
51. SIGNATURE OF DECEASED (None)		52. SIGNATURE OF WITNESS JAMES EARL RAY		53. SIGNATURE OF PHYSICIAN JAMES EARL RAY		54. SIGNATURE OF CORONER JAMES EARL RAY		55. SIGNATURE OF JURY JAMES EARL RAY	
56. SIGNATURE OF DECEASED (None)		57. SIGNATURE OF WITNESS JAMES EARL RAY		58. SIGNATURE OF PHYSICIAN JAMES EARL RAY		59. SIGNATURE OF CORONER JAMES EARL RAY		60. SIGNATURE OF JURY JAMES EARL RAY	
61. SIGNATURE OF DECEASED (None)		62. SIGNATURE OF WITNESS JAMES EARL RAY		63. SIGNATURE OF PHYSICIAN JAMES EARL RAY		64. SIGNATURE OF CORONER JAMES EARL RAY		65. SIGNATURE OF JURY JAMES EARL RAY	
66. SIGNATURE OF DECEASED (None)		67. SIGNATURE OF WITNESS JAMES EARL RAY		68. SIGNATURE OF PHYSICIAN JAMES EARL RAY		69. SIGNATURE OF CORONER JAMES EARL RAY		70. SIGNATURE OF JURY JAMES EARL RAY	
71. SIGNATURE OF DECEASED (None)		72. SIGNATURE OF WITNESS JAMES EARL RAY		73. SIGNATURE OF PHYSICIAN JAMES EARL RAY		74. SIGNATURE OF CORONER JAMES EARL RAY		75. SIGNATURE OF JURY JAMES EARL RAY	
76. SIGNATURE OF DECEASED (None)		77. SIGNATURE OF WITNESS JAMES EARL RAY		78. SIGNATURE OF PHYSICIAN JAMES EARL RAY		79. SIGNATURE OF CORONER JAMES EARL RAY		80. SIGNATURE OF JURY JAMES EARL RAY	
81. SIGNATURE OF DECEASED (None)		82. SIGNATURE OF WITNESS JAMES EARL RAY		83. SIGNATURE OF PHYSICIAN JAMES EARL RAY		84. SIGNATURE OF CORONER JAMES EARL RAY		85. SIGNATURE OF JURY JAMES EARL RAY	
86. SIGNATURE OF DECEASED (None)		87. SIGNATURE OF WITNESS JAMES EARL RAY		88. SIGNATURE OF PHYSICIAN JAMES EARL RAY		89. SIGNATURE OF CORONER JAMES EARL RAY		90. SIGNATURE OF JURY JAMES EARL RAY	
91. SIGNATURE OF DECEASED (None)		92. SIGNATURE OF WITNESS JAMES EARL RAY		93. SIGNATURE OF PHYSICIAN JAMES EARL RAY		94. SIGNATURE OF CORONER JAMES EARL RAY		95. SIGNATURE OF JURY JAMES EARL RAY	
96. SIGNATURE OF DECEASED (None)		97. SIGNATURE OF WITNESS JAMES EARL RAY		98. SIGNATURE OF PHYSICIAN JAMES EARL RAY		99. SIGNATURE OF CORONER JAMES EARL RAY		100. SIGNATURE OF JURY JAMES EARL RAY	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

06209

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Wash.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cavetown</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Washington County Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Earl David Paden</b>				4. DATE OF DEATH Month Day Year <b>May 17, 19 58</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 18, 1877</b>		9. AGE (In years lost birthday) yrs. <b>80</b>		10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>labor</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>general work</b>		11. BIRTHPLACE (State or foreign country) <b>Leitersburg, Md.</b>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <b>Oliver Paden</b>				14. MOTHER'S MAIDEN NAME <b>Kate Burger</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service)		17. INFORMANT Address <b>Walter Spessard, Smithsburg, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Degeneration</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized Arteriosclerosis</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>490x Lobar Pneumonia</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 Mo.</b> <b>5 Yrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. p. p. m. Month, Day, Year <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>4/4</b> , 19 <b>55</b> , to <b>5/17</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>5/17</b> , 19 <b>58</b> , and that death occurred at <b>8:35 P.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Charles F. Hess</b> M.D. <b>Smithsburg, Md.</b> <b>5-19-58</b>							
ACTUAL SIGNATURE <b>Charles F. Hess</b> M.D. <b>Smithsburg, Md.</b> <b>5-19-58</b>							
PHYSICIAN'S NAME (Type) <b>Charles F. Hess M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>5-20-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Smithsburg Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Smithsburg, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich</b>				ADDRESS <b>2uSon, Smithsburg, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 21 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Scott F. Minnich</b>			







# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06210

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Wash.</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>29 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>36 Cramer Ave</b>			d. STREET ADDRESS <b>36 Cramer Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Effie</b> Middle <b>Elizabeth</b> Last <b>Palmer</b>			4. DATE OF DEATH Month <b>May</b> Day <b>24</b> , Year <b>1958</b>		
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 4, 1903</b>	9. AGE (In years last birthday) <b>55</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>house wife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Greencastle, Penna.</b>	
13. FATHER'S NAME <b>John J. Eshleman</b>			14. MOTHER'S MAIDEN NAME <b>Myrtle Spidle</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>--</b>		17. INFORMANT Address <b>Harry Mummert, Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cerebral Hemorrhage</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>3221 Chronic Alcoholism</b>					INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>none</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>None 19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>	
20f. (City or town) <b>--</b>		20g. (County) <b>--</b>		20h. (State) <b>--</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>S. Robert Wells</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>May 26'58</b>	
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>5-27-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Marion Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Marion, Penna.</b>		22e. (State) <b>--</b>		22f. (Country) <b>--</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son, Hagerstown, Md.</b>			24a. REC'D BY REGISTRAR DATE <b>MAY 29 1958</b>		24b. REGISTRAR'S SIGNATURE <b>W. J. Leach</b>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MAINTAIN STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: John A. Linneman  
AGE: 28 years  
RESIDENCE: 18 Orange Ave.  
DATE OF DEATH: May 21, 1901  
PLACE OF DEATH: Home  
CAUSE OF DEATH: Chorea  
DISEASE OR INJURY: Chorea  
MANNER OF DEATH: Not known  
SIGNATURE OF EXAMINER: Henry H. Linneman, M.D.

TESTIMONY OF WITNESSES:  
1. John A. Linneman  
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100. John A. Linneman



6207

Items 13, 14, 15, 17 Film G229 6-2-58 et

## CERTIFICATE OF DEATH

Reg. Dist. No.

06211

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>FREDERICK.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>				c. LENGTH OF STAY IN 1b <u>63 DYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WESTERN MARYLAND STATE HOSPITAL</u>				e. STREET ADDRESS <u>115 EAST 5TH ST.</u>			
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>PLEASANT</u> Last <u>PLEASANT</u>				4. DATE OF DEATH Month <u>MAY</u> Day <u>22</u> Year <u>1958</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>COLORED</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/8/1880</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Not given</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Isaac Pleasant</u>				14. MOTHER'S MAIDEN NAME <u>Ellen Jackson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Hospital Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONFLUENT LOBULAR PNEUMONIA BILATERAL</u> 148x 3 WEEKS DUE TO (b) <u>PULMONARY CONGESTION &amp; EDEMA</u> 2 DYS. DUE TO (c) <u>SQUAMOUS CELL CARCINOMA OF PHARYNX</u> 6 MOS. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ARTERIOSCLEROTIC HEART DISEASE.</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MAR. 20, 1958</u> , to <u>MAY 22, 1958</u> , that I last saw the deceased alive on <u>MAY 22, 1958</u> , and that death occurred at <u>10:35 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>George Berce, M.D.</u>				ADDRESS (Street, city or town, state) <u>1500 PENNSYLVANIA AVE. MD.</u> DATE SIGNED <u>5/23/58</u>			
PHYSICIAN'S NAME (Type) <u>DR. G. BERCE</u>				<u>HAGERSTOWN, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>				<u>Fairview Cemetery</u>		<u>Fredrick Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. H. Berce</u>				ADDRESS <u>Hagerstown Maryland</u>		24c. REC'D BY REGISTRAR	
						24b. REGISTRAR'S SIGNATURE <u>Alfred Smith</u>	
				DATE <u>MAY 26 1958</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MASSACHUSETTS DEPARTMENT OF HEALTH-BALTIMORE, MD



6208

06212

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>3 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Wash. Co. Hospital</b>		e. STREET ADDRESS <b>438 Carrollton Ave.,</b>	
3. NAME OF DECEASED (Type or print) <b>Earl</b>		4. DATE OF DEATH Month <b>5</b> Day <b>15</b> Year <b>19 58</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 10, 1894</b>
9. AGE (In years last birthday) <b>64</b> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>City Water Dept.</b>	
11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Phillip Rager</b>		14. MOTHER'S MAIDEN NAME <b>Rose Rhodes</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-09-8971</b>	
17. INFORMANT <b>Mrs. Aileen Rowland</b>		Address <b>Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Artery Embolus</b> DUE TO (c) <b>arterio-sclerotic Heart Dis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 1/2 hrs</b> <b>5 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>4-1-58</b> , 19 <b>58</b> , to <b>5-15</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>5-14-58</b> , 19 <b>58</b> , and that death occurred at <b>6 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>A. E. W. Deth</b>		ADDRESS (Street, city or town, state) <b>Hagerstown Md</b>	
PHYSICIAN'S NAME (Type) <b>A. E. W. Deth Jr</b>		DATE SIGNED <b>5/15/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	22b. DATE THEREOF <b>5-17-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill</b>	22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Fred W. Kraiss</b>		ADDRESS <b>Hagerstown, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>MAY 20 1958</b>		24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH



Name of Deceased		Sex		Age	
Date of Birth		Place of Birth		Usual Residence	
Cause of Death		Duration of Illness		Time of Death	
Place of Death		Occupation		Education	
Manner of Death		Signature of Physician		Signature of Registrar	
Date of Death		Time of Death		Place of Death	

*Central Public Health*  
*Central Public Health*

*1-15-22*  
*1-15-22*  
*1-15-22*  
*1-15-22*



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0209

CERTIFICATE OF DEATH

06213

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				d. STREET ADDRESS <u>55 Elizabeth St.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First <u>JOHN</u>		Middle <u>WILLIAM</u>		Last <u>REED</u>	
4. DATE OF DEATH		Month <u>May</u>		Day <u>17</u>		Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 15, 1958</u>		9. AGE (In years last birthday) yrs. <u>2</u>		IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u> Hours <u>2</u> Min. <u>2</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Kelley Reed</u>				14. MOTHER'S MAIDEN NAME <u>Shirley Viola Boward</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>None</u>		17. INFORMANT Address <u>Wm.K.Reed 55 Elizabeth St. Hagerstown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subarachnoid Hemorrhage</u> <u>760.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/15/1958</u> , to <u>5/17/1958</u> , that I last saw the deceased alive on <u>5/17/1958</u> , and that death occurred at <u>8:45 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. M. Bacon Jr</u>				ADDRESS (Street, city or town, state) <u>302 N. Potomac St Hagerstown Md.</u>			
PHYSICIAN'S NAME (Type) <u>A. M. BACON Jr</u>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/19/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Rest Haven Funeral Chapel Inc. Hagerstown, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 20 1958</u>		24b. REGISTRAR'S SIGNATURE <u>Quilley</u>	



CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, possibly "John Doe"]		SEX [Faint text, possibly "Male"]		AGE [Faint text, possibly "45"]	
DATE OF DEATH [Faint text, possibly "Jan 15, 1925"]		TIME OF DEATH [Faint text, possibly "10:30 AM"]		PLACE OF DEATH [Faint text, possibly "Home"]	
CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		MANNER OF DEATH [Faint text, possibly "Natural"]		PLACE OF BIRTH [Faint text, possibly "Chicago, Ill."]	
OCCASION OF DEATH [Faint text, possibly "While at work"]		PREVIOUS ILLNESS [Faint text, possibly "None"]		PREVIOUS SURGERY [Faint text, possibly "None"]	
NAME OF PHYSICIAN [Faint text, possibly "Dr. J. H. Smith"]		NAME OF FUNERAL HOME [Faint text, possibly "None"]		NAME OF BURIAL PLACE [Faint text, possibly "None"]	
NAME OF WITNESS [Faint text, possibly "None"]		NAME OF CORONER [Faint text, possibly "None"]		NAME OF JURY [Faint text, possibly "None"]	
NAME OF COUNTY CLERK [Faint text, possibly "None"]		NAME OF STATE CLERK [Faint text, possibly "None"]		NAME OF VICE CLERK [Faint text, possibly "None"]	

RECEIVED

TO BUREAU OF VITAL STATISTICS



0210

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>				c. LENGTH OF STAY IN 1b <b>25 YRS.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>				d. STREET ADDRESS <b>MARYLAND HOTEL</b>			
3. NAME OF DECEASED (Type or print) First <b>CLAUDE</b> Middle <b>LEONARD</b> Last <b>RITTER SR.</b>				4. DATE OF DEATH Month <b>MAY</b> Day <b>24</b> Year <b>19 58</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1/21/1902</b>	
9. AGE (In years last birthday) <b>56 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>OFFICE CLERK</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>COAL CO.</b>		11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>THEODORE RITTER</b>				14. MOTHER'S MAIDEN NAME <b>LYDIA POSTEN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no, unknown) <b>NO</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>214-09-2986</b>			
17. INFORMANT Address <b>HAGERSTOWN MD.</b>				17. INFORMANT <b>MRS. HALLIE R. RITTER</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY EDEMA</b> 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>METASTATIC PULMONARY CARCINOMA 6 MONTHS</b> DUE TO <b>CARCINOMA RECTUM (COLLOID)</b> 6-12 mo. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>MALNUTRITION &amp; ALCOHOLISM</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>MAY 20, 1958</b> , to <b>MAY 24, 1958</b> , that I last saw the deceased alive on <b>MAY 24, 1958</b> , and that death occurred at <b>3 P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>318 N. Potomac St.</b> DATE SIGNED							
ACTUAL SIGNATURE <b>Paul Harrison</b> M.D. <b>Hagerstown, Md.</b>							
PHYSICIAN'S NAME (Type) <b>Paul Harrison, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>5/27/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>HAGERSTOWN MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>W. J. Normont, Hagerstown, Md.</b>							
24a. REC'D BY REGISTRAR DATE <b>MAY 28 '58</b>				24b. REGISTRAR'S SIGNATURE <b>W. J. Normont</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MASSACHUSETTS STATE DEPARTMENT OF HEALTH—BOSTON OFFICE

682



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

06215  
302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Wash. County Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>THOMAS ELBERT ROACH Jr</b>		4. DATE OF DEATH Month Day Year <b>May 21 1958 19</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 13 1904</b>
9. AGE (In years last birthday) <b>54</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Store Keeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self employed Bluefield Mercer Co</b>	
11. BIRTHPLACE (State or foreign country) <b>W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thomas E. Roach, Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Carrie Snead</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>317-32-5289</b>	
17. INFORMANT Address <b>Mrs Margaret H. Roach 109 Calvert Ter.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>601X</b> DUE TO <b>Alumina</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pylonephritis, ureteral strictures, bilateral hydronephrosis</b> (c) <b>Unidiagnosed disease of left lung.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>about 7 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Unidiagnosed disease of left lung.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1-11, 1950</b> , to <b>5-21, 1958</b> , that I last saw the deceased alive on <b>5-20, 1958</b> , and that death occurred at <b>3:15 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>154 West Washington St., Hagerstown Wash. Co Md.</b> DATE SIGNED <b>5-21-58</b>			
ACTUAL SIGNATURE <b>John H. Hornbaker</b> M.D.		DATE SIGNED <b>5-21-58</b>	
PHYSICIAN'S NAME (Type) <b>John H. Hornbaker, M.D.</b>		Hagerstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5/23/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Hagerstown Wash. Co Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>		ADDRESS <b>Hagerstown Md.</b>	
24a. REC'D BY REGISTRAR <b>MAY 23 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Seach</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06212

## CERTIFICATE OF DEATH

06216

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN TB <b>1 year</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>20 N. Potomac Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Ollie</b> Middle <b>Franklin</b> Last <b>Rose</b>				4. DATE OF DEATH Month <b>May</b> Day <b>12</b> Year <b>1958</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 1, 1881</b>		9. AGE (In years lost birthday) yrs. <b>76</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Macedonia, Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Ewell Rose</b>				14. MOTHER'S MAIDEN NAME <b>Eliza Grove</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>319-20-3967</b>		17. INFORMANT Address <b>Melvin Rose- 365 Central Ave- Hagerstown, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>arteriosclerotic coronary heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <b>acute coronary occlusion</b> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>None</b> 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>None</b>		20f. (City or town) (County) (State) <b>- - -</b>	
21. I certify that I attended the deceased from <b>June</b> , 19 <b>54</b> to <b>May 12</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>May 3</b> , 19 <b>58</b> , and that death occurred at <b>4:15 P. M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>S. Robert Wells</b>				ADDRESS (Street, city or town, state) <b>115 N. Potomac Street</b>		DATE SIGNED <b>5-13-58</b>	
PHYSICIAN'S NAME (Type) <b>S. Robert Wells, M.D.</b>				<b>Hagerstown, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-15-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Macedonia Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Macedonia, Va. Frederick Co</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>				ADDRESS <b>Hagerstown, Md</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 15 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Over</b>			



THE KANSAS STATE DEPARTMENT OF HEALTH—ANNOUNCEMENT



## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>7 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>			
d. STREET ADDRESS <b>Gordon Circle</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ANNIE</b> Middle <b>LAURIE</b> Last <b>ROULETTE</b>				4. DATE OF DEATH Month <b>May</b> Day <b>7</b> Year <b>1958</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 8, 1890</b>	
9. AGE (In years last birthday) <b>67</b> yrs.		IF UNDER 1 YEAR Months <b>6</b> Days <b>29</b>		IF UNDER 24 HRS. Hours <b></b> Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b></b>		11. BIRTHPLACE (State or foreign country) <b>Suffolk, Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Samuel Edward Haynes</b>				14. MOTHER'S MAIDEN NAME <b>Laura Lawrence</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mrs. Laura Wright</b>		Address <b>Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastases - generalized</b> <b>154X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of rectum</b> DUE TO (c) <b></b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b> <b>3 yr.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 21</b> , 19 <b>57</b> , to <b>May 7</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>May 7</b> , 19 <b>58</b> , and that death occurred at <b>8:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Hagerstown, Md.</b> DATE SIGNED <b>5/8/58</b>							
ACTUAL SIGNATURE <b>Chas. Hoffman</b> M.D.				PHYSICIAN'S NAME (Type) <b>214 N. Pat. St.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/10/1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Suter-Houzer Funeral Home</b> <b>R. Hamilton Hays</b>				ADDRESS <b>Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 13 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Alfred</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06218

Reg. Dist. No. 302

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Washington</u> <span style="float: right;">6214</span> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>4 Hrs</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash County Hospital</u>				d. STREET ADDRESS <u>343 Ridge Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>CHARLES WILLIAM StCLAIR</u>				<b>4. DATE OF DEATH</b> Month <u>May</u> Day <u>22</u> Year <u>1958</u>		19 <u>19</u>	
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Feby 16 1896</u>	
<b>9. AGE</b> (In years last birthday) <u>62</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>		<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Unable to work</u>	
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Injured</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Boonsboro Wash. Co Md</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>		<b>13. FATHER'S NAME</b> <u>William St Clair</u>	
<b>14. MOTHER'S MAIDEN NAME</b> <u>Sally Mitchell</u>		<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>Yes</u> (If yes, give year or dates of service) <u>W.V.# 1</u>		<b>16. SOCIAL SECURITY NO.</b> <u>None</u>		<b>17. INFORMANT</b> <u>Mrs Sally M. St Clair</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary occlusion</u> DUE TO (b) <u>Chronic bronchial asthma with bronchiectasis</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. <u>241x</u>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Tubes Dorsalis</u>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/></b> <u>None</u>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>  </u> o. m. <u>none</u> p. m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While of work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>none</u>		<b>20f. (City or town)</b> <u>  </u> (County) <u>  </u> (State) <u>  </u>	
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.</b>							
<b>ACTUAL SIGNATURE</b> <u>S. Robert Wells</u> <b>M.D.</b>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>EXAMINER'S NAME (Type)</b> <u>S. Robert Wells, M.D.</u>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>				<b>DATE SIGNED</b> <u>5-22-58</u>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>May 24/58</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Rose Hill Cemetery</u>		<b>22d. LOCATION (City, town, or county)</b> (State) <u>Hagerstown, Maryland.</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Andrew K. Coffman</u>				<b>ADDRESS</b> <u>Hagerstown. Md.</u>		<b>24a. REC'D BY REGISTRAR</b> <b>DATE</b> <u>MAY 26 '58</u>	
<b>24b. REGISTRAR'S SIGNATURE</b> <u>[Signature]</u>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate during the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



STATE DEPARTMENT OF HEALTH - BALTIMORE 13  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF ATTENDING PHYSICIAN		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF WITNESSES		17. SIGNATURE OF FUNERAL HOME		18. SIGNATURE OF BURIAL PLACE	
19. SIGNATURE OF CEMETERY		20. SIGNATURE OF INTERVIEWER		21. SIGNATURE OF INTERVIEWEE	
22. SIGNATURE OF INTERVIEWER		23. SIGNATURE OF INTERVIEWEE		24. SIGNATURE OF INTERVIEWER	
25. SIGNATURE OF INTERVIEWEE		26. SIGNATURE OF INTERVIEWER		27. SIGNATURE OF INTERVIEWEE	
28. SIGNATURE OF INTERVIEWER		29. SIGNATURE OF INTERVIEWEE		30. SIGNATURE OF INTERVIEWER	
31. SIGNATURE OF INTERVIEWEE		32. SIGNATURE OF INTERVIEWER		33. SIGNATURE OF INTERVIEWEE	
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43. SIGNATURE OF INTERVIEWEE		44. SIGNATURE OF INTERVIEWER		45. SIGNATURE OF INTERVIEWEE	
46. SIGNATURE OF INTERVIEWER		47. SIGNATURE OF INTERVIEWEE		48. SIGNATURE OF INTERVIEWER	
49. SIGNATURE OF INTERVIEWEE		50. SIGNATURE OF INTERVIEWER		51. SIGNATURE OF INTERVIEWEE	
52. SIGNATURE OF INTERVIEWER		53. SIGNATURE OF INTERVIEWEE		54. SIGNATURE OF INTERVIEWER	
55. SIGNATURE OF INTERVIEWEE		56. SIGNATURE OF INTERVIEWER		57. SIGNATURE OF INTERVIEWEE	
58. SIGNATURE OF INTERVIEWER		59. SIGNATURE OF INTERVIEWEE		60. SIGNATURE OF INTERVIEWER	
61. SIGNATURE OF INTERVIEWEE		62. SIGNATURE OF INTERVIEWER		63. SIGNATURE OF INTERVIEWEE	
64. SIGNATURE OF INTERVIEWER		65. SIGNATURE OF INTERVIEWEE		66. SIGNATURE OF INTERVIEWER	
67. SIGNATURE OF INTERVIEWEE		68. SIGNATURE OF INTERVIEWER		69. SIGNATURE OF INTERVIEWEE	
70. SIGNATURE OF INTERVIEWER		71. SIGNATURE OF INTERVIEWEE		72. SIGNATURE OF INTERVIEWER	
73. SIGNATURE OF INTERVIEWEE		74. SIGNATURE OF INTERVIEWER		75. SIGNATURE OF INTERVIEWEE	
76. SIGNATURE OF INTERVIEWER		77. SIGNATURE OF INTERVIEWEE		78. SIGNATURE OF INTERVIEWER	
79. SIGNATURE OF INTERVIEWEE		80. SIGNATURE OF INTERVIEWER		81. SIGNATURE OF INTERVIEWEE	
82. SIGNATURE OF INTERVIEWER		83. SIGNATURE OF INTERVIEWEE		84. SIGNATURE OF INTERVIEWER	
85. SIGNATURE OF INTERVIEWEE		86. SIGNATURE OF INTERVIEWER		87. SIGNATURE OF INTERVIEWEE	
88. SIGNATURE OF INTERVIEWER		89. SIGNATURE OF INTERVIEWEE		90. SIGNATURE OF INTERVIEWER	
91. SIGNATURE OF INTERVIEWEE		92. SIGNATURE OF INTERVIEWER		93. SIGNATURE OF INTERVIEWEE	
94. SIGNATURE OF INTERVIEWER		95. SIGNATURE OF INTERVIEWEE		96. SIGNATURE OF INTERVIEWER	
97. SIGNATURE OF INTERVIEWEE		98. SIGNATURE OF INTERVIEWER		99. SIGNATURE OF INTERVIEWEE	
100. SIGNATURE OF INTERVIEWER		101. SIGNATURE OF INTERVIEWEE		102. SIGNATURE OF INTERVIEWER	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

06219

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Pa.</u> b. COUNTY <u>Franklin</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Greencastle</u> 75X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. Co. Hospital</u>		d. STREET ADDRESS <u>RD1 - Greencastle</u>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>KATIE</u> Last <u>SHANK</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>30</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 10, 1884</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Antrim Twp., Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John S. Shank</u>		14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Baumgardner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Noah Shank</u>		Address <u>RD1 Greencastle, Pa.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive cardiovascular disease</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>April 29, 1958. Intrauterine radium implantation. Carcinoma (adeno) of uterine fundus. Exploratory laparotomy 5/21/58.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/25/58</u> , 19 <u>58</u> , to <u>5/30/58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>5/30/58</u> , 19 <u>58</u> , and that death occurred at <u>8:15 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W.C. Brewer</u>		M.D. <u>Greencastle, Penna.</u>	
PHYSICIAN'S NAME (Type) <u>W.C. Brewer, M.D.</u>		DATE SIGNED <u>5/31/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>B.</u>	22b. DATE THEREOF <u>June 3, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Grove Cem. near Greencastle, Pa.</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.E. Munich - Greencastle, Pa.</u>		24a. REC'D BY REGISTRAR <u>W.E. Munich</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE	



CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 45 years	
4. DATE OF DEATH April 28, 1938		5. TIME OF DEATH 10:30 AM		6. PLACE OF DEATH Home	
7. CAUSE OF DEATH Hypertensive cardiovascular disease		8. MANNER OF DEATH Natural		9. MEDICAL HISTORY Hypertension, 10 years	
10. SIGNATURE OF PHYSICIAN J. C. Brown, M.D.		11. SIGNATURE OF DEATH REGISTRAR [Signature]		12. SIGNATURE OF WITNESS [Signature]	
13. PLACE OF BIRTH [Blank]		14. DATE OF BIRTH [Blank]		15. OCCUPATION [Blank]	
16. MARITAL STATUS [Blank]		17. EDUCATION [Blank]		18. RELIGION [Blank]	
19. PREVIOUS MARRIAGES [Blank]		20. PREVIOUS DEATHS [Blank]		21. PREVIOUS ILLNESSES [Blank]	
22. PREVIOUS SURGERIES [Blank]		23. PREVIOUS TRAUMAS [Blank]		24. PREVIOUS ACCIDENTS [Blank]	
25. PREVIOUS DRUGS [Blank]		26. PREVIOUS ALCOHOL [Blank]		27. PREVIOUS TOBACCO [Blank]	
28. PREVIOUS OTHER [Blank]		29. PREVIOUS OTHER [Blank]		30. PREVIOUS OTHER [Blank]	



6241 CERTIFICATE OF DEATH

06220

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MAPLEVILLE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MAPLEVILLE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>00 MAIN STREET</b>		d. STREET ADDRESS <b>MAIN STREET</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ADA</b> Middle <b>L.</b> Last <b>SHIFLER</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>16</b> Year <b>1958</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 4 1878</b>
9. AGE (In years last birthday) <b>80</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HO USEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>MAPLEVILLE WASH.CO.MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CHARLES KELLER</b>		14. MOTHER'S MAIDEN NAME <b>MISSOURI TRACY</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>NONE</b>	
17. INFORMANT <b>W. MERLE SHIFLER MAPLEVILLE MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ventricular fibrillation</b> <b>420.1</b> DUE TO <b>Coronary occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis generalized</b> (c) <b>Thyroid adenoma</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Thyroid adenoma</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>7 minutes</b> <b>6 days</b> <b>indefinite</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1954</b> , 19____, to <b>present</b> , 19____, that I last saw the deceased alive on <b>May 15, 1958</b> , and that death occurred at <b>12:15</b> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Robert J. Keadle M.D.</b>		ADDRESS (Street, city or town, state) <b>Hagerstown Md</b>	
DATE SIGNED <b>5-17-58</b>			
PHYSICIAN'S NAME (Type) <b>Robert J. Keadle</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>MAY 19 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>BOONSBORO CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>BOONSBORO WASH.CO.MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>East Sunil House Boonsboro Md</b>		24a. REC'D BY REGISTRAR <b>DATE MAY 19 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Al. Branch</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

For Use by

Physician or other person authorized by law to sign

Physician

Signature

Date

Place

Signature

Date

Place

Signature

Date

Place

Signature

Date

Place

Signature

Date

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 302

06221

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>6 months</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>525 E. Franklin Street</b>				d. STREET ADDRESS <b>525 E. Franklin Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JANET</b> First <b>A.</b> Middle <b>SHIRK</b> Last				4. DATE OF DEATH Month <b>May</b> Day <b>8</b> Year <b>1958</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 24, 1872</b>		9. AGE (In years last birthday) <b>85</b> yrs. <b>8</b> Months <b>11</b> Days <b>11</b> Hours <b>11</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Juniata County, Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry Shirk</b>				14. MOTHER'S MAIDEN NAME <b>Sophia Yeakle</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Marshall Hall</b> Address <b>Hagerstown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331X Vascular hypertension</b> DUE TO <b>Acute Cerebral hemorrhage</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>none</b> 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f. (City or town) (County) (State) <b>- - -</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>S. Robert Wells</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED	
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/12/1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Paul's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Suter-Rouzer Funeral Home</b>				24a. REC'D BY REGISTRAR <b>DATE MAY 13 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Overseer</b>	

VS. A15ME  
5M 2/57

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH	
JAMES H. HARRIS		45		M		W		JAN 10 1918	
RESIDENCE		CITY		COUNTY		STATE		MARRIED	
1234 E. BALTIMORE ST.		BALTIMORE		BALTIMORE		MD		YES	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		DATE OF BURIAL	
LABORER		HEART DISEASE		NATURAL		HOME		JAN 12 1918	
PREVIOUS ILLNESS		SIGNS AND SYMPTOMS		TREATMENT		POST-MORTEM		FINDINGS	
NONE		PAIN IN CHEST		NONE		NO		NO	
DATE OF EXAMINATION		SIGNATURE OF EXAMINER		TITLE		COUNTY		STATE	
JAN 10 1918		J. H. HARRIS		M.D.		BALTIMORE		MD	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06222

6242

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hancock Maryland.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Gate Way Nursing Home</u>		d. STREET ADDRESS <u>Hancock Maryland.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Josephine</u> Middle <u>Benton</u> Last <u>Shives</u>		4. DATE OF DEATH Month <u>5</u> Day <u>9</u> Year <u>19 58</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 6 1887</u>
9. AGE (In years last birthday) yrs. <u>70</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Hancock Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Shafer Reel</u>		14. MOTHER'S MAIDEN NAME <u>Fannie Bryan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Preston Shives Hancock Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Bowel</u> <u>153.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Hemorrhage</u> INTERVAL BETWEEN ONSET AND DEATH <u>6 mo.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 15, 1954</u> to <u>May 9, 1958</u> , that I last saw the deceased alive on <u>May 9, 1958</u> , and that death occurred at <u>6:10 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>David R. Brewer</u> M.D.		ADDRESS (Street, city or town, state) <u>Clear Spring Md</u> DATE SIGNED <u>5/11/58</u>	
PHYSICIAN'S NAME (Type) <u>David R. Brewer</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5.12.58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Shives Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hancock Washington Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard J. Stone Hancock Md</u>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <u>MAY 15 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Alfred</u>	



CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		AGE	
OCCUPATION		SEX	
CAUSE OF DEATH		MANNER OF DEATH	
DATE OF BIRTH		PLACE OF BIRTH	
FATHER'S NAME		MOTHER'S NAME	
EDUCATION		RELIGION	
MARRIAGE		PREVIOUS MARRIAGES	
SPECIAL INSTRUCTIONS		SIGNATURE OF DECEASED	
SIGNATURE OF WITNESSES		SIGNATURE OF PHYSICIAN	
SIGNATURE OF CLERK		SIGNATURE OF REGISTRAR	

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, STATE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND.



## 6243 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural- Boonsboro</u>				c. LENGTH OF STAY IN 1b <u>10 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Fahrney Keedy Memorial Home</u>				d. STREET ADDRESS <u>Rural- Myersville 10X-2</u>			
3. NAME OF DECEASED (Type or print) First <u>ANNIE S.</u> Middle <u>STOTTLEMYER</u> Last				4. DATE OF DEATH Month <u>May</u> Day <u>2</u> Year <u>1958</u> 19			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 30, 1873</u>		9. AGE (In years last birthday) <u>84</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife Ret.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Daniel Marker</u>				14. MOTHER'S MAIDEN NAME <u>Cynthia Bowman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>records of Fahrney Keedy Home, Boonsboro, Md. Rt. #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of liver</u> <u>156.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Embolic</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u> <u>1 month</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 2, 1958</u> , to <u>May 2, 1958</u> , that I last saw the deceased alive on <u>May 1, 1958</u> , and that death occurred at <u>4:15 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>G. W. LeVan</u> M.D.				ADDRESS (Street, city or town, state) <u>Boonsboro</u>		DATE SIGNED <u>5-2-58</u>	
PHYSICIAN'S NAME (Type) <u>G. W. LeVan</u>				<u>Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURYAL</u>		22b. DATE THEREOF <u>MAY 4, '58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Grossnickle's</u>		22d. LOCATION (City, town, or county) (State) <u>Nr. Myersville, Fred. Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Paul F. Bittle</u>				ADDRESS <u>Myersville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 6 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Deckerich</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

NAME OF DECEASED JAMES E. HARRIS		SEX Male	
DATE OF BIRTH May 2, 1918		PLACE OF BIRTH Baltimore, Maryland	
OCCUPATION Laborer		MARITAL STATUS Single	
DATE OF DEATH May 10, 1940		PLACE OF DEATH Baltimore, Maryland	
TIME OF DEATH 11:00 AM		CAUSE OF DEATH Myocardial Infarction	
MEDICAL HISTORY No previous illness		MANNER OF DEATH Natural	
SIGNATURE OF DECEASED (None)		SIGNATURE OF WITNESSES (None)	
SIGNATURE OF PHYSICIAN (None)		SIGNATURE OF CORONER (None)	
SIGNATURE OF REGISTRAR (None)		SIGNATURE OF CLERK (None)	

BC 1154 MAY 11 1940  
 1154 MAY 11 1940



6244

# CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE		Maryland		b. COUNTY		Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)							
Rural Hagerstown		4 months		03 Hagerstown							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
Gateway Convalescent Home				116 Fairground Ave.							
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		Month Day Year	
BESSIE				LUGENE		STOTTEMYER		May		6 19 58	
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		October 11, 1873		84		Months 6 Days 25		Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
Housework				Wolfsville, Maryland		U.S.A.					
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME							
William Shuff				Mary Myers							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address					
no		none		Mrs. Mary Lear		Hagerstown, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Infarct 463X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Phlebothrombosis, right leg DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive, arteriosclerotic cardio-vascular disease								INTERVAL BETWEEN ONSET AND DEATH 3 days 7 days		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
				Hour a. m. p. m. 19		While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					
21. I certify that I attended the deceased from April 29, 1958, to May 6, 1958, that I last saw the deceased alive on May 6, 1958, and that death occurred at 7:10 PM, from the causes and on the date stated above.											
ACTUAL SIGNATURE Archie Robert Cohen M.D.				ADDRESS (Street, city or town, state)				DATE SIGNED			
PHYSICIAN'S NAME (Type) Archie Robert Cohen, M.D.				Clear Spring, Maryland				05/07/58			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)					
Burial		5/9/1958		Mt. Zion Cemetery		Mapleville, Maryland					
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE					
Suter-Rouzer Funeral Home R. Franklin Rouzer Hagerstown, Md.				DATE MAY 13 '58		Alfred Leach					

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be defaced for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in no event within 72 hours after death.

VS AIS (4)  
15M 9/55







Reg. Dist. No. 302

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Washington</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>1 Hr</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Wash. County Hospital</b>				d. STREET ADDRESS <b>1228 So Locust st</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MABEL</b>		First <b>REBECCA</b>		Middle <b>STRALEY</b>		Last <b>May 8 1958</b>	
4. DATE OF DEATH Month Day Year <b>19</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>Jany 19 1899</b>		9. AGE (In years last birthday) <b>59</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mangle Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Troy Laundry</b>		11. BIRTHPLACE (State or foreign country) <b>Frederick Fred. Co Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles Palmer</b>				14. MOTHER'S MAIDEN NAME <b>Amanda Daugherty</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-18-0045</b>		17. INFORMANT <b>James H. Straley 228 So Locust st</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		Hagerstown Md. <b>Coronary Occlusion</b> <b>Hypertensive Cardiovascular Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>8 yrs.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify, that I attended the deceased from <b>11/8</b> , 19 <b>58</b> , to <b>May 8</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>May 8</b> , 19 <b>58</b> , and that death occurred at <b>9:15</b> M., from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <b>Philip J. Hirshman, M.D.</b> M.D. <b>159 W. Washington St., Hagerstown, Md. 5/9/58</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/11/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) <b>Hagerstown Wash. Co Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>				ADDRESS <b>Hagerstown Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 13 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Alfred</b>			

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4

VS A1S (4)  
ISM 10/S7







6218

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Jackson Convelasent Home</b>		d. STREET ADDRESS <b>52 East Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>BLANCHE E. SUMMERS</b>		4. DATE OF DEATH Month <b>May</b> Day <b>16</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/20/1872</b>
9. AGE (In years lost birthday) yrs. <b>85</b>		10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Ezra Burtner</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Harp</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>John C.L. Summers, 52 East Ave., Hagerstown</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Advanced generalized arteriosclerosis</b> <b>422.1</b> DUE TO Arterio-sclerotic Myocardial heart disease with acute myocardial failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>8yrs</b> <b>11yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>	
20c. TIME OF INJURY Hour o. m. p. m. <b>None</b> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>None</b>		20f. (City or town) (County) (State) <b>- - -</b>	
21. I certify that I attended the deceased from <b>Oct. 48</b> , to <b>May 16</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>May 13</b> , 19 <b>58</b> , and that death occurred at <b>8:50A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>S. Robert Wells</b> M.D.		ADDRESS (Street, city or town, state) <b>115 N. Potomac Street</b> DATE SIGNED <b>5-17-58</b>	
PHYSICIAN'S NAME (Type) <b>S. Robert Wells, M.D.</b>		<b>Hagerstown, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	22b. DATE THEREOF <b>5/19/1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Reformed Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Middletown, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Gladhill Company, Middletown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 20 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Arch...</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.



6219

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>11 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>			
f. STREET ADDRESS <b>761 S. Potomac Street</b>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Elias</b> Last <b>Sumner</b>				4. DATE OF DEATH Month <b>May</b> Day <b>24</b> Year <b>1958</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 4, 1885</b>		9. AGE (In years lost birthday) <b>73 yrs.</b>	IF UNDER 1 YEAR Months <b>4</b> Days <b>20</b> Hours <b></b> Min. <b></b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired C.P.O.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Navy</b>		11. BIRTHPLACE (State or foreign country) <b>Fairview, Iowa</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Sumner</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Ackers</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>W.W. I&amp;II</b>		17. INFORMANT <b>Mrs. Florence E. Sumner</b>		Address <b>Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular Collapse</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Rupture Myo cardium</b> DUE TO (c) <b>Coronary Occlusion</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Min</b> <b>2 Wks.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Hagerstown</b>		(County) <b>Maryland</b>		
21. I certify that I attended the deceased from <b>May 13</b> , 19 <b>58</b> , to <b>May 24</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>May 24</b> , 19 <b>58</b> , and that death occurred at <b>5:40 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Louis G. Graff</b>				ADDRESS (Street, city or town, state) <b>119 E. Antietam</b>		DATE SIGNED <b>5-26-58</b>	
PHYSICIAN'S NAME (Type) <b>Louis G. GRAFF M.D.</b>				<b>Hagerstown Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5/27/1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) <b>Hagerstown</b>		(State) <b>Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>P. Franklin Rye</b>				ADDRESS <b>Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 28 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Alfred</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

PLACE OF DEATH		DATE OF DEATH	
HOME		JAN 10 1933	
NAME OF DECEASED		AGE	
JOHN J. JAMES		65	
SEX		M	
RACE		W	
BIRTH DATE		BIRTH PLACE	
JAN 10 1868		BALTIMORE, MD	
OCCUPATION		CAUSE OF DEATH	
LABORER		HEART DISEASE	
PREVAILING DISEASE		MANNER OF DEATH	
CORONARY ARTERY DISEASE		NATURAL	
DATE OF INTERMENT		PLACE OF INTERMENT	
JAN 12 1933		BALTIMORE, MD	
NAME OF FUNERAL HOME		SIGNATURE OF REGISTRAR	
JAMES J. JAMES		[Signature]	
NAME OF WITNESS		DATE	
JOHN J. JAMES		JAN 10 1933	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH AND IS NOT VALID FOR ANY OTHER PURPOSE. IT IS THE POLICY OF THE DEPARTMENT TO MAINTAIN THE ACCURACY OF THE RECORDS AND TO PROVIDE FOR THE PROTECTION OF THE PUBLIC HEALTH. THE DEPARTMENT IS NOT RESPONSIBLE FOR THE CONSEQUENCES OF THE USE OF THIS CERTIFICATE FOR ANY OTHER PURPOSE.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06228

6220

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Hagerstown</b>			
c. LENGTH OF STAY IN 1b <b>4 days</b>				d. STREET ADDRESS <b>Route 1</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Edward Latimore Thompson</b>				4. DATE OF DEATH Month <b>May</b> Day <b>27</b> Year <b>1958</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 10, 1870</b>	
9. AGE (In years last birthday) yrs. <b>88</b>		IF UNDER 1 YEAR Months <b>27</b> Days <b>27</b> Hours <b>27</b> Min. <b>27</b>		IF UNDER 24 HRS. Months <b>27</b> Days <b>27</b> Hours <b>27</b> Min. <b>27</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Compositor</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Printing</b>		11. BIRTHPLACE (State or foreign country) <b>Waynesboro Pa.</b>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <b>Samuel S. Thompson</b>				14. MOTHER'S MAIDEN NAME <b>Susanna Cramer</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>Mrs. Alice Troxell Hag. Rt. 1</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Generalized peritonitis</b> <b>154x</b> DUE TO <b>Perforated Sigmoid Colon</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Adeno - Ca of recto - sigmoid colon</b> (c) <b>?</b>							INTERVAL BETWEEN ONSET AND DEATH <b>72 hrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <b>11</b> p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>May 24, 1958</b> to <b>May 27, 1958</b> , that I last saw the deceased alive on <b>May 27, 1958</b> , and that death occurred at <b>1:20 p.m.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>John A. Moran</b>				ADDRESS (Street, city or town, state) <b>215 W. Washington St.</b>			
DATE SIGNED <b>5/28/58</b>							
PHYSICIAN'S NAME (Type) <b>John A. Moran, M.D.</b>				Hagerstown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-29-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Funkstown Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Funkstown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son</b>				ADDRESS <b>Hagerstown Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 2 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Allen Smith</b>							



STATE DEPARTMENT OF HEALTH - BALTIMORE 18



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06229

6221

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>X Williamsport</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County</b>		d. STREET ADDRESS <b>R.F.D.# 1</b>	
3. NAME OF DECEASED (Type or print) First <b>Theron</b> Middle <b>Clay</b> Last <b>Tolley</b>		4. DATE OF DEATH Month <b>May</b> Day <b>3</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 23, 1948</b>
9. AGE (in years last birthday) <b>9</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Grade School</b>	11. BIRTHPLACE (State or foreign country) <b>Martinsburg W.Va.</b>
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13. FATHER'S NAME <b>Truman B. Tolley</b>	
14. MOTHER'S MAIDEN NAME <b>Berlen J. Roudabush</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Truman B. Tolley Williamsport Md. R.F.D. #1</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Concussion severe</b> <b>813X</b> DUE TO <b>Fracture, femur, tibia &amp; fibula, left</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Shock secondary.</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>While riding bicycle child struck by automobile</b>	
20c. TIME OF INJURY Month, Day, Year <b>6:15 p.m. 5/3/ 1958</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>1 mi. west Downsville (Downsville) Washington MD.</b>	20f. (City or town) (County) (State) <b>Williamsport Rt. #1</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Dr. E.W. Ditto, Jr.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Dr. E.W. Ditto, Jr.</b>		DATE SIGNED <b>5/3/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5/6/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rosedale Cemetary</b>	22d. LOCATION (City, town, or county) (State) <b>Martinsburg W.Va.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard K. Brown</b>		24a. REC'D BY REGISTRAR <b>MAY 16 '58</b> DATE	
		24b. REGISTRAR'S SIGNATURE <b>W. Leach</b>	



NEW YORK STATE  
HEALTH DEPT.  
BUREAU OF VITAL STATISTICS

1

Name of Deceased		Sex		Age	
John J. Kelly		Male		35	
Date of Death		Place of Death		Cause of Death	
Jan. 15, 1912		New York City		Heart Disease	
Time of Death		Occupation		Signature of Examiner	
10:30 A.M.		Clerk		[Signature]	
Address of Deceased		Signature of Informant		Date of Report	
1234 5th Ave.		[Signature]		Jan. 16, 1912	
City and State		Signature of Registrar		Date of Registration	
New York City		[Signature]		Jan. 16, 1912	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6245

Item 1 Film G229 6-6-58 et

## CERTIFICATE OF DEATH

Reg. Dist. No. 06230

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boonsboro Rural</u>				c. LENGTH OF STAY IN 1b <u>2 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Daughter's home</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Sheridan</u> First Middle Last <u>Toms</u>				4. DATE OF DEATH Month <u>5</u> Day <u>27</u> Year <u>1958</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/25/1864</u>	
9. AGE (In years lost birthday) <u>93</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farm owner, ret.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>farm</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Abram Toms</u>				14. MOTHER'S MAIDEN NAME <u>Susan Bowman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Route # 2</u> <u>Mrs. Granville Easterday, Boonsboro, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>5 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>11/2</u> , 19 <u>57</u> , to <u>5/27</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>5/27</u> , 19 <u>58</u> , and that death occurred <u>11:15</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Eldon E. Baker, MD</u> M.D.				ADDRESS (Street, city or town, state) <u>Smithsburg, Md</u> DATE SIGNED <u>5/27/58</u>			
PHYSICIAN'S NAME (Type) <u>Eldon E. Baker, MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>5/23/1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Bethel Methodist Cem., Frederick Co., Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Gladhill Company, Middletown, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 2 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. J. Leach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6246

## CERTIFICATE OF DEATH

06231

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Smithsburg</u> c. LENGTH OF STAY IN 1b <u>58 Years</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>12 E. Water St.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Smithsburg</u> d. STREET ADDRESS <u>12 E. Water St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>Minnie</u> Middle <u>L.</u> Last <u>Tracey</u>		4. DATE OF DEATH Month <u>May</u> Day <u>27</u> Year <u>1958</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 11, 1877</u>	9. AGE (In years last birthday) <u>80 yrs.</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Duties</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Garfield, Fred. Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Denton Kuhn</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca Forrest</u>		17. INFORMANT <u>Mrs. Paul Boswell, Smithsburg Md.</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Paul Boswell, Smithsburg Md.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u> <u>600.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic pyelonephritis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic heart disease, Generalized arterioscl.</u> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)						INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>2 years</u>
21. I certify that I attended the deceased from <u>May 24</u> , 19 <u>58</u> , to <u>May 26</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>May 26</u> , 19 <u>58</u> , and that death occurred at <u>6:05a</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Smithsburg Md.</u> DATE SIGNED <u>5/27/58</u>						
ACTUAL SIGNATURE <u>Eldon E Baker, MD</u>		M.D. <u>Smithsburg Md.</u>		DATE SIGNED <u>5/27/58</u>		
PHYSICIAN'S NAME (Type) <u>Eldon E Baker, MD</u>		<u>Smithsburg</u>		<u>Md.</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/29/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Smithsburg</u>		22d. LOCATION (City, town, or county) (State) <u>Smithsburg, Wash. Co., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Z. Grove, Waynesboro Pa.</u>		ADDRESS <u>Waynesboro Pa.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 28 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Walter Z. Grove</u>



# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

## CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH	
JAMES M. BROWN		45		M		W		10/15/1918	
PLACE OF BIRTH		DATE OF BIRTH		PLACE OF DEATH		DATE OF DEATH		TIME OF DEATH	
BALTIMORE, MD.		10/10/1873		BALTIMORE, MD.		10/15/1918		10:30 AM	
CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		MEDICAL ATTENDANT		PLACE OF INTERMENT	
PNEUMONIA		NATURAL		PNEUMONIA		DR. J. H. SMITH		CATHARTIC	
DATE OF INTERVIEW		NAME OF INTERVIEWER		NAME OF WITNESS		NAME OF WITNESS		NAME OF WITNESS	
10/16/1918		J. H. SMITH		J. H. SMITH		J. H. SMITH		J. H. SMITH	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF MEDICAL ATTENDANT		SIGNATURE OF INTERVIEWER		SIGNATURE OF WITNESS	
DATE OF INTERVIEW		NAME OF INTERVIEWER		NAME OF WITNESS		NAME OF WITNESS		NAME OF WITNESS	
10/16/1918		J. H. SMITH		J. H. SMITH		J. H. SMITH		J. H. SMITH	



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6222

## CERTIFICATE OF DEATH

06232

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>W. Va.</u> b. COUNTY <u>Morgan</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>8 hrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berkeley Springs</u> <u>85x-3</u>	
3. NAME OF DECEASED (Type or print) First <u>Barbara</u> Middle <u>Ann</u> Last <u>Tritapoe</u>		4. DATE OF DEATH Month <u>May</u> Day <u>1</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 29, 1958</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>1</u> Days <u>1</u> Hours <u>3</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Morgan Co., W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Harold Tritapoe</u>		14. MOTHER'S MAIDEN NAME <u>Deloris Clingerman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Harold Tritapoe</u>		Address <u>Berkeley Springs, W.V.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congenital Heart Disease (Cor-Tritoculore)</u> <u>7545</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/30</u> , 19 <u>58</u> , to <u>5/1</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>4/30</u> , 19 <u>58</u> , and that death occurred at <u>1:50 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. M. Bacon Jr</u>		DATE SIGNED <u>5/5/58</u>	
PHYSICIAN'S NAME (Type) <u>Hagerstown, Md.</u>		ADDRESS (Street, city or town, state) <u>302 N. Potomac St</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-2-78</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Highland</u>		22d. LOCATION (City, town, or county) (State) <u>Morgan Co. W. Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John S. Turner</u>		ADDRESS <u>Berkeley Springs, W. Va.</u>	
24a. REC'D BY REGISTRAR <u>MAY 6 58</u>		24b. REGISTRAR'S SIGNATURE <u>W. K. ...</u>	



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6223

## CERTIFICATE OF DEATH

Dr. Robt. Campbell

Reg. Dist. No. 302

06233

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>1 week</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Cty. Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Joshua</u> Middle <u>Earl</u> Last <u>Troupe</u>		4. DATE OF DEATH Month <u>May</u> Day <u>7</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 8, 1882</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Huyetts, R. F. D. 6</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joshua J. Troupe</u>		14. MOTHER'S MAIDEN NAME <u>Lida Pittinger</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>420-28-8690</u>	
17. INFORMANT <u>Mrs. Cora S. Troupe</u>		Address <u>502 Summit Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/25</u> , 19 <u>58</u> , to <u>5/7/58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>5/7/58</u> , 19 <u>58</u> , and that death occurred at <u>11:30 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert V. L. Campbell</u> M.D.		ADDRESS (Street, city or town, state) <u>145 W Washington St</u>	
PHYSICIAN'S NAME (Type) <u>Robert V. L. Campbell</u>		DATE SIGNED <u>5/9/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-10-1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		ADDRESS <u>Hagerstown, Md.</u>	
24a. REC'D BY REGISTRAR <u>MAY 13 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Alfred Leach</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Blank form with horizontal lines for text entry.

MADE IN U.S.A.  
100-111437

100-111437  
100-111437  
100-111437











1 **MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

**6225**

**CERTIFICATE OF DEATH**

Reg. Dist. No. **06235**

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Va.</b> b. COUNTY <b>Shenandoah</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>2 Months</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Martin Manor Rest Home</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Strasburg</b> <b>83X-3</b>	
		d. STREET ADDRESS	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>Leslie</b> Last <b>Whittington</b>		4. DATE OF DEATH Month <b>May</b> Day <b>20</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 5, 1885</b>
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Molder</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Zepp, Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Martin Whittington</b>		14. MOTHER'S MAIDEN NAME <b>Julia Ann Willis</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Maud Little, Waynesboro Penna.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Spinal cord tumor with metastasis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>metastasis</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Prostatic hypertrophy - benign</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Apr 25, 1958</b> to <b>May 19, 1958</b> , that I last saw the deceased alive on <b>May 17, 1958</b> , and that death occurred at <b>3 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>217 W. Washington Street</b> DATE SIGNED <b>5/21/58</b>			
ACTUAL SIGNATURE <b>Edward W. Ditto III</b> M.D. <b>217 W. Washington Street</b> <b>5/21/58</b>			
PHYSICIAN'S NAME (Type) <b>Edward W. Ditto III, M.D., Hagerstown, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5/22/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Green Hill</b>	22d. LOCATION (City, town, or county) (State) <b>Waynesboro, Franklin Pa.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter J. Grove, Waynesboro Pa.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 23 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Oliver</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of informant		12. Date of registration	
13. Name of informant		14. Address of informant		15. Telephone number	
16. Name of funeral home		17. Address of funeral home		18. Telephone number	
19. Name of cemetery		20. Address of cemetery		21. Telephone number	
22. Name of undertaker		23. Address of undertaker		24. Telephone number	
25. Name of physician		26. Address of physician		27. Telephone number	
28. Name of registrar		29. Address of registrar		30. Telephone number	
31. Name of informant		32. Address of informant		33. Telephone number	
34. Name of funeral home		35. Address of funeral home		36. Telephone number	
37. Name of cemetery		38. Address of cemetery		39. Telephone number	
40. Name of undertaker		41. Address of undertaker		42. Telephone number	
43. Name of physician		44. Address of physician		45. Telephone number	
46. Name of registrar		47. Address of registrar		48. Telephone number	
49. Name of informant		50. Address of informant		51. Telephone number	
52. Name of funeral home		53. Address of funeral home		54. Telephone number	
55. Name of cemetery		56. Address of cemetery		57. Telephone number	
58. Name of undertaker		59. Address of undertaker		60. Telephone number	
61. Name of physician		62. Address of physician		63. Telephone number	
64. Name of registrar		65. Address of registrar		66. Telephone number	
67. Name of informant		68. Address of informant		69. Telephone number	
70. Name of funeral home		71. Address of funeral home		72. Telephone number	
73. Name of cemetery		74. Address of cemetery		75. Telephone number	
76. Name of undertaker		77. Address of undertaker		78. Telephone number	
79. Name of physician		80. Address of physician		81. Telephone number	
82. Name of registrar		83. Address of registrar		84. Telephone number	
85. Name of informant		86. Address of informant		87. Telephone number	
88. Name of funeral home		89. Address of funeral home		90. Telephone number	
91. Name of cemetery		92. Address of cemetery		93. Telephone number	
94. Name of undertaker		95. Address of undertaker		96. Telephone number	
97. Name of physician		98. Address of physician		99. Telephone number	
100. Name of registrar		101. Address of registrar		102. Telephone number	

1. Name of deceased

2. Sex

3. Age

4. Date of death

5. Time of death

6. Place of death

7. Cause of death

8. Manner of death

9. Signature of physician

10. Signature of registrar

11. Signature of informant

12. Date of registration

13. Name of informant

14. Address of informant

15. Telephone number

16. Name of funeral home

17. Address of funeral home

18. Telephone number

19. Name of cemetery

20. Address of cemetery

21. Telephone number

22. Name of undertaker

23. Address of undertaker

24. Telephone number

25. Name of physician

26. Address of physician

27. Telephone number

28. Name of registrar

29. Address of registrar

30. Telephone number

31. Name of informant

32. Address of informant

33. Telephone number

34. Name of funeral home

35. Address of funeral home

36. Telephone number

37. Name of cemetery

38. Address of cemetery

39. Telephone number

40. Name of undertaker

41. Address of undertaker

42. Telephone number

43. Name of physician

44. Address of physician

45. Telephone number

46. Name of registrar

47. Address of registrar

48. Telephone number

49. Name of informant

50. Address of informant

51. Telephone number

52. Name of funeral home

53. Address of funeral home

54. Telephone number

55. Name of cemetery

56. Address of cemetery

57. Telephone number

58. Name of undertaker

59. Address of undertaker

60. Telephone number

61. Name of physician

62. Address of physician

63. Telephone number

64. Name of registrar

65. Address of registrar

66. Telephone number

67. Name of informant

68. Address of informant

69. Telephone number

70. Name of funeral home

71. Address of funeral home

72. Telephone number

73. Name of cemetery

74. Address of cemetery

75. Telephone number

76. Name of undertaker

77. Address of undertaker

78. Telephone number

79. Name of physician

80. Address of physician

81. Telephone number

82. Name of registrar

83. Address of registrar

84. Telephone number

85. Name of informant

86. Address of informant

87. Telephone number

88. Name of funeral home

89. Address of funeral home

90. Telephone number

91. Name of cemetery

92. Address of cemetery

93. Telephone number

94. Name of undertaker

95. Address of undertaker

96. Telephone number

97. Name of physician

98. Address of physician

99. Telephone number

100. Name of registrar

101. Address of registrar

102. Telephone number



6247

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>		c. LENGTH OF STAY IN lb <u>4 yrs. 6 mos. 3 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hancock</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Williamsport Sanitarium</u>				d. STREET ADDRESS <u>Hancock</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>J.</u> Last <u>Wiener</u>				4. DATE OF DEATH Month <u>May</u> Day <u>1</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 17, 1863</u>		9. AGE (In years last birthday) <u>95</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>TANNERY Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Andrew Wiener</u>				14. MOTHER'S MAIDEN NAME <u>Anna M Cutshall</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO. <u>213-12-7296</u>		17. INFORMANT <u>Andrew S Wiener Frederick Maryland.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Arterio Sclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>10 yr</u> (c) <u>10 yr</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7-1-1937</u> to <u>5-1-1958</u> , that I last saw the deceased alive on <u>4-30-58</u> , 19 <u>58</u> , and that death occurred at <u>12:10</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>N. EW Little</u>		M.D. <u>Augustine</u>		ADDRESS (Street, city or town, state) <u>325 P</u>		DATE SIGNED <u>5-1-58</u>	
PHYSICIAN'S NAME (Type) <u>Dr. F. W. Little</u>		M.D. <u>Augustine</u>		ADDRESS (Street, city or town, state) <u>325 P</u>		DATE SIGNED <u>5-1-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5.3.58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Peters Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hancock Washington Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard J. Leone</u>				ADDRESS <u>Hancock Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 6 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Alfred</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1875

*[Faint handwritten notes at the bottom of the page, possibly bleed-through from the reverse side.]*



6248

## CERTIFICATE OF DEATH

06237

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL</b>		c. LENGTH OF STAY IN 1b <b>LIFE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>BOONSBORO MD. ROUTE 2</b>		d. STREET ADDRESS <b>BOONSBORO MD. ROUTE 2</b>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>WALTER</b> Last <b>WILKINSON</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>12</b> Year <b>1958</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DEC. 8 1879</b>
9. AGE (In years last birthday) <b>78</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>VICTOR PROD. CORP. BOONSBORO MD.</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>LAWSON WILKINSON</b>		14. MOTHER'S MAIDEN NAME <b>JULIA</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>219 20 0653</b>	
17. INFORMANT <b>MRS. ERNEST POFFENBERGER BOONSBORO MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>10 months</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> Not work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 12</b> , 19 <b>58</b> , to <b>May 12</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>May 12</b> , 19 <b>58</b> , and that death occurred at <b>11 P.</b> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>G. W. HeVan</b>		ADDRESS (Street, city or town, state) <b>Boonsboro</b>	
PHYSICIAN'S NAME (Type) <b>G. W. HeVan</b>		DATE SIGNED <b>5/14/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>MAY 15 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>BOONSBORO CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>BOONSBORO WASH. CO. MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>East Funeral Home Boonsboro Md.</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>May 19 58</b>		24b. REGISTRAR'S SIGNATURE <b>Quinn</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



U.S. DEPARTMENT OF HEALTH - BALT. FORK

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06238

6249

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Wash.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Smithsburg</b>				c. LENGTH OF STAY IN 1b <b>life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6 S. Main St.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Ella</b> Middle <b>Gray</b> Last <b>Wishard</b>				4. DATE OF DEATH Month <b>May</b> Day <b>18</b> Year <b>1958</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 29, 1873</b>	
9. AGE (In years last birthday) <b>84</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>owner</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Hotel</b>		11. BIRTHPLACE (State or foreign country) <b>Smithsburg, Md.</b>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <b>Joseph A. Wishard</b>				14. MOTHER'S MAIDEN NAME <b>Anna Davis</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Mesenteric Thrombosis</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardiac Decompensation</b> DUE TO (c) <b>Arterio Sclerosis (generalized)</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>25 hours</b> <b>2 wks</b> <b>15 yrs</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>4-36-58</b> to <b>5-18-58</b> , that I last saw the deceased alive on <b>5-18-58</b> , 19 <b>58</b> , and that death occurred at <b>3:16 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Smithsburg Md</b> DATE SIGNED <b>5/19/58</b>							
ACTUAL SIGNATURE <b>S. G. Kohler</b> M.D.				PHYSICIAN'S NAME (Type) <b>G. A. KOHLER</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>5-20-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Smithsburg Masoleum</b>		22d. LOCATION (City, town, or county) (State) <b>Smithsburg, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son, Smithsburg, Md.</b>				24a. REC'D BY REGISTRAR <b>MAY 21 '58</b>		24b. REGISTRAR'S SIGNATURE	



CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth	
John A. Smith		Male		35		Jan 15, 1900	
Place of Birth		Cause of Death		Date of Death		Time of Death	
New York City		Heart Disease		Jan 20, 1935		10:30 AM	
Occupation		Hospital		Physician		Burial Place	
Teacher		St. Mary's		Dr. J. B. Jones		Catholic Cemetery	
Signature of Physician		Signature of Registrar		Signature of Burial Officer		Signature of Witness	
J. B. Jones		John A. Smith		John A. Smith		John A. Smith	

*John A. Smith*  
*Heart Disease*  
*Jan 20, 1935*  
*10:30 AM*  
*St. Mary's*  
*Dr. J. B. Jones*  
*Catholic Cemetery*  
*Teacher*  
*Signature of Physician*  
*Signature of Registrar*  
*Signature of Burial Officer*  
*Signature of Witness*  
*J. B. Jones*  
*John A. Smith*  
*John A. Smith*  
*John A. Smith*



6250

CERTIFICATE OF DEATH

06239

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Smithsburg		c. LENGTH OF STAY IN 1b 36 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Smithsburg #2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Vera May Wolf		4. DATE OF DEATH Month Day Year May 29, 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 22, 1906
9. AGE (In years last birthday) yrs. 52		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Duties	
11. BIRTHPLACE (State or foreign country) Prophetstown, Ill.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ora Harshman		14. MOTHER'S MAIDEN NAME Alma Hammond	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Janice Munson, Smithsburg Md., #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> 414 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Valvular heart disease</u> DUE TO (c) <u>Rheumatic fever inactive</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. — 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April</u> , 19 <u>50</u> , to <u>May 29</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>May 29</u> , 19 <u>58</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Walter X Woejinger</u>		M.D. <u>122 So Broad St Waynesboro Pa</u> 5-30-58	
PHYSICIAN'S NAME (Type)		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/1/58	
22c. NAME OF CEMETERY OR CREMATORY Smithsburg		22d. LOCATION (City, town, or county) (State) Smithsburg, Washington Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter X Woejinger</u>		24a. REC'D BY REGISTRAR DATE JUN 2 '58	
ADDRESS <u>Waynesboro, Pa</u>		24b. REGISTRAR'S SIGNATURE <u>W. Woejinger</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

VS. A15ME  
SM 2/57

Item 18 Film 230 8-9-58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6226

06240

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Funkstown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A- Emergency Room- Hospital		d. STREET ADDRESS 30 W. Baltimore St.	
3. NAME OF DECEASED (Type or print) George Gene Wood		4. DATE OF DEATH May 8, 19 58	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 3, 1932 25 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) assembler		11. BIRTHPLACE (State or foreign country) Hagerstown, Md.	
13. FATHER'S NAME Walter Wood		14. MOTHER'S MAIDEN NAME Eleanor Hunt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 220-28-2807	
17. INFORMANT Mrs. Eleanor Wood, Funkstown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Arteriosclerotic coronary artery heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE S. Robert Wells, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 5-9-58	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 5-11-58	
22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md.		24. REC'D BY REGISTRAR MAY 12 58	
ADDRESS		24b. REGISTRAR'S SIGNATURE	



30 W. Ball Lane

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED DATE 08-11-2010 BY 60322 UCBAW

779 3406315310 1258



6227

## CERTIFICATE OF DEATH

06241

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>Hagerstown</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>D.O.A.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				e. STREET ADDRESS <u>500 Grove Ave.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>HARRY</u> <u>MAXWELL</u> <u>YINGLING</u>				4. DATE OF DEATH Month Day Year <u>May</u> <u>8</u> <u>19 58</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 18, 1901</u>	9. AGE (In years lost birthday) yrs. <u>56</u>	IF UNDER 1 YEAR Months <u>11</u> Days <u>20</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>President</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Auto Dealer</u>		11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harry L. Yingling</u>				14. MOTHER'S MAIDEN NAME <u>Goldie Garver</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>217-28-6826</u>		17. INFORMANT <u>Mrs. Alice J. Yingling</u>		Address <u>Hagerstown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u> DUE TO <u>Coronary Atherosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>4 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive Vascular Disease</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>12/13</u> , 19 <u>47</u> to <u>5/8</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>5/8/58</u> , 19 <u></u> , and that death occurred at <u>11:30 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>99 E. Potomac Ave</u> DATE SIGNED <u>5/17/58</u> ACTUAL SIGNATURE <u>Dalton M. Walty</u> M.D. <u>99 E. Potomac Ave</u> PHYSICIAN'S NAME (Type) <u>DALTON M. WELTY</u> <u>Hagerstown</u> <u>Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5/11/1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Suter-Houzer Funeral Home</u> <u>R. G. Gentry</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 13 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







6251 CERTIFICATE OF DEATH

06242

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hancock</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hancock Md.</u>			
c. LENGTH OF STAY IN <u>Life</u>				d. STREET ADDRESS <u>Hancock Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Jacob</u> Middle <u>Austin</u> Last <u>Younker</u>				4. DATE OF DEATH Month <u>5</u> Day <u>31</u> Year <u>1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4.17.1869</u>		9. AGE (In years last birthday) <u>89</u> yrs.	IF UNDER 1 YEAR: Months <u>1</u> Days <u>14</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer (Retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Washington County Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Issac Younker</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Hull</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs Herman Phillips Hancock Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> <u>422.2</u> DUE TO <u>Senility</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	
				20f. (City or town) <u></u> (County) <u></u> (State) <u></u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I attended the deceased from <u>May 31, 1958</u> to <u>May 31, 1958</u> , that I last saw the deceased alive on <u>Good May 31, 1958</u> , and that death occurred at <u>8:00</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. M. Shopper</u> M.D.				ADDRESS (Street, city or town, state) <u>Hancock</u> DATE SIGNED <u>6/1/58</u>			
PHYSICIAN'S NAME (Type) <u></u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6.3.58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Stone Bridge Brothorn</u>		22d. LOCATION (City, town, or county) (State) <u>Near Hancock Washington Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard J. Hume</u> ADDRESS <u>Hancock Md.</u>				24a. REC'D BY REGISTRAR <u></u> DATE <u>JUN 6 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Alfred</u>	







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6252 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Hancock</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Hayes</u> Middle <u>Roy</u> Last <u>Zies</u>		4. DATE OF DEATH Month <u>5</u> Day <u>26</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1.5.1945</u>
9. AGE (In years last birthday) <u>13</u> yrs.		IF UNDER 1 YEAR Months <u>4</u> Days <u>20</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Student</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington County Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harold E Zies</u>		14. MOTHER'S MAIDEN NAME <u>Marietta M Douglas</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Harold E Zies Hancock Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sarcoma of Right lung.</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec. 18</u> , 19 <u>57</u> , to <u>May 26</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>May 21</u> , 19 <u>58</u> , and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. O. Martin</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>111 S. Spring Martinsburg W. Va 5-28-58</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5.29.58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Near Hancock Washington Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard J. Hines</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 2 '58</u>	
ADDRESS <u>Hancock Md.</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u>	



1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6228 CERTIFICATE OF DEATH

Reg. Dist. No. 06244

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pa.</u> b. COUNTY <u>Franklin</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dagersstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greencastle</u> 75 x -3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. Co. Hospital</u>		d. STREET ADDRESS <u>140 S. Allison St.</u>	
3. NAME OF DECEASED (Type or print) <u>John Wesley Zimmerman</u> First Middle Last		4. DATE OF DEATH <u>May 12</u> Month Day Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/9/1866</u>
9. AGE (In years last birthday) <u>92</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter &amp; General work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>State Line, Pa.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Henry N. Zimmerman</u>		14. MOTHER'S MAIDEN NAME <u>Eva Miller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>204-01-9759</u>	
17. INFORMANT <u>Mrs. Elva Zimmerman</u> Address <u>Greencastle Pa.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>904.0 Uremia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fractured left hip</u> DUE TO (c) <u>Tumor of the bladder</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 wks</u> <u>3 wks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypo-static pneumonia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell at home</u>	
20c. TIME OF INJURY Hour o. m. p. m. <u>4/26/58</u> Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Greencastle Franklin Penna.</u>	
21. I certify that I attended the deceased from <u>April 26</u> , 19 <u>58</u> , to <u>May 12</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>May 12</u> , 19 <u>58</u> , and that death occurred at <u>5:40p</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paul F. Webster</u> M.D.		DATE SIGNED <u>5/13/58</u>	
PHYSICIAN'S NAME (Type) <u>Paul F. Webster, M.D.</u>		<u>Greencastle, Pennsylvania</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>5/14/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Greencastle, Pa.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. G. Winnich</u> ADDRESS <u>Greencastle, Pa.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 15 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>W. J. Schuch</u>	



CERTIFICATE OF DEATH

1928

PLACE OF DEATH HOME		SEX MALE	
RACE WHITE		AGE 45	
DATE OF DEATH MAY 12 1928		TIME OF DEATH 10:30 AM	
PLACE OF BIRTH PENNSYLVANIA		OCCUPATION LABORER	
NAME OF DECEASED JOHN J. HENRY		NAME OF FATHER JOHN J. HENRY	
NAME OF MOTHER MARY J. HENRY		NAME OF SPOUSE MARY J. HENRY	
NAME OF NEXT OF KIN MARY J. HENRY		NAME OF PHYSICIAN DR. J. H. HENRY	
NAME OF BURIAL PLACE ST. ANNE'S CATHEDRAL		NAME OF MINISTER REV. J. H. HENRY	
NAME OF FUNERAL HOME ST. ANNE'S CATHEDRAL		NAME OF CEMETERY ST. ANNE'S CATHEDRAL	
NAME OF INTERVIEWER ST. ANNE'S CATHEDRAL		NAME OF REGISTRAR ST. ANNE'S CATHEDRAL	
NAME OF CLERK ST. ANNE'S CATHEDRAL		NAME OF ASSISTANT ST. ANNE'S CATHEDRAL	
NAME OF DECEASED JOHN J. HENRY		NAME OF FATHER JOHN J. HENRY	
NAME OF MOTHER MARY J. HENRY		NAME OF SPOUSE MARY J. HENRY	
NAME OF NEXT OF KIN MARY J. HENRY		NAME OF PHYSICIAN DR. J. H. HENRY	
NAME OF BURIAL PLACE ST. ANNE'S CATHEDRAL		NAME OF MINISTER REV. J. H. HENRY	
NAME OF FUNERAL HOME ST. ANNE'S CATHEDRAL		NAME OF CEMETERY ST. ANNE'S CATHEDRAL	
NAME OF INTERVIEWER ST. ANNE'S CATHEDRAL		NAME OF REGISTRAR ST. ANNE'S CATHEDRAL	
NAME OF CLERK ST. ANNE'S CATHEDRAL		NAME OF ASSISTANT ST. ANNE'S CATHEDRAL	

RECEIVED MAY 30 1928